Problem behaviour	Manifestation	Behaviours to promote	Barriers to ideal behaviour	Factors encouraging ideal behaviour	Programme Communication		Social mobilisation	Advocacy
					Primary Target	Secondary Target		
3. Parents and caretakers not aware of next NIDs and routine EPI and therefore do not take children for immunisation	Low coverage High morbidity High mortality	parents to bring children parents to encourage others to take children	Illiteracy false rumours parents and caretakers un-informed about side effects	- health workers can be trained - volunteers are available - influential people can be involved - health committees are established - willingness of parents - women's groups - shuras (council)	Parents and caretakers	Grand parents, relatives & community leaders		

Problem behaviour	Manifestation	Behaviours to promote	Barriers to ideal behaviour	Factors encouraging ideal behaviour	Programme Communication		Social mobilisation	Advocacy
					Primary Target	Secondary Target		
4. communities are not involved in NIDs planning and AFP surveillance	low coverage AFP cases are not reported Communities are not empowered	Communities involved in NIDs planning and AFP surveillance	Inadequate training of health workers reluctance to empower communities limited budget no transport no experience of involvement with communities vertical and top down programming	Available: - health workers and TBAs - health facilities - health educators - social mobilisers - FAO livestock vaccinators - Community based organisations	- Community leaders - Shura - Teachers - Mullah - Women groups - Volunteers - Elderly people	District Health Director District Health Administration Vice and Virtue Department	UN and NGOs	

2. Communication Channel Analysis

Channels	Strong Points	Weak Points
Group communication		
Workshop	Large coverage possible by training of trainers	Limited number of the participants Time consuming Expensive
Public gathering	High coverage Cheap	Not participatory No consensus No feedback
Meetings	Feedback Consensus Concentrated High coverage Visualisation	Limited number of participants No feedback No understanding Expensive
Parade	High coverage Visualisation	No feedback Vague Expensive
One to one communication:		
Inter-Personal Communication (eg. TBA & mother, vaccinator/mother, social mobilisers/parents, doctor's counseling)	Direct feedback Two way communication Common understanding More interaction Problem solving Human factor Effective Flexibility Persuation, and interesting	Low coverage Process slow (time) High human resources Communication bias Chance of inaccurate messages Costly
Mass Media:		
Radio	Wide coverage Variety of languages Cost effective 24 hours Loyal/habitual	Delayed feedback Limited access Language problem One time listening
News Papers	Wide circulation Permanent reference Read by influential people	Limited access Only literate population Censorship Printing technology might fail
Television	Attractive Variety of attractions Effective Also illiterate people can benefit	Limited coverage Dependent on electricity Costly Limited access

Day - 3

1. **Group Norms (for workshop participants)**
   - do not interrupt
   - say positive things before less positive ones
   - good listening
   - respect other opinions
   - ask for opinions
   - everybody should be given a chance
   - do not dominate discussions
   - stick to the topic
   - sharp and brief comments
   - chairpersons in group work facilitate so that everybody participates

2. **Hard to reach population and analysis/strategy**

Hard to reach group	Problem	Experiences	Strategy/activity	Partners
New borns	Traditional beliefs of risk for 40 days (prone to evil spirits)	TBA interactive with parents; Mullahs have knowledge	Home to home visits Special messages on media and other channels	Mullah TBAs
Nomadic people	Mobility, scattered and drought	Check posts for NIDs	Use seasonal pattern of migration	Mobile teams
Isolated areas	- No access/no roads - Coordination - Weather conditions (snow) - Weak planning	Starts planning earlier Micro planning Cross border arrangmt. Take climate into account while planing	Start planning long time in advance and use partners from other countries	Partners and NGOs
Conflict areas	Fighting IDPs Mines	Negotiated cease-fire Early morning and late evening vaccinations to avoid shooting time	Approach local authorities to discuss cease-fire. Negotiations can work.	
Disabled children	Negligence and discrimination		Research needed. Special programme for disabled.	
Children in urban slums	Omission and left out in planning	Use information about slums including IDPs	Improved planning and supervision	
Ethnic and religious minorities	Living in isolated areas; other people do not want to serve them		Research needed and target explicitly	
Poor people	Discrimination by health workers and vaccinators		Motivate health workers/vaccinators	
Urban elite				

3. **Issues for further research**
   - To what extent does literacy affect the knowledge, attitude and behaviour of parents towards immunisation?
   - New borns
   - Neglect of children with disability? Scope? What can be done?
   - Ethnic/religious minorities: why are they not getting immunisation
   - Newspapers
   - Effectiveness of radio
   - Boys/girls equity

   Note: see day 4, paragraph 3 for follow-up.

4. **Selection of communication channels for participants/audiences**

a: Selection Criteria:
- pattern of use
- what do people like (not what we like, example the puppet show)
- frequency
- credibility
- affordability
- effectiveness/appropriateness (culturally and socially acceptable)
- accessibility
- different channels play different roles
- mix channels simultaneously to have reinforcing effects

b: communication channels for participants/audience

Target	Channel	Group affiliated	Where do people spend time?	Whom do they consult	Who else can influence target audience?
Local authorities and medical professionals perceive polio eradication as Afghan priority					
District administration, Health Director, medical staff	Individual meetings, group briefings, news-papers, official directors, educational materials	Religious groups	Health facilities Officers	Health Directors Health staff and Provincial Health Director	Governor, Provincial Health Director, elderly community leaders
EPI/polio service providers communicate effectively with parents/ caretakers					
Vaccinators, volunteers, social mobilisers, EPI focal points	Workshops, training courses, group meetings, orientation workshops	People within the community	Health facilities, mosques, shuras	DHC REMT PEMT	DHC Traditional healers, health staff
Parents/caretakers take children for immunisation					
Parents, caretakers, grandparents relatives	Radio, peer to peers, women to women, public gatherings	Religious network (esp. for influential people), None for parents/ caretakers	Home, mosque, listening to radio, clinic, marriage ceremonies,	Health workers, TBAs, traditional healers, doctors	Mullahs, religious leaders, shrine, gudar.

Communities are involved in NIDs planning					
Community leaders, women groups, shura	One to one meetings, group meetings, radio	Organisation, local authorities		Medical officers Women	Community organisations

5. Communication Objectives and Indicators:

- Objectives need to be "SMART": ➔ **S** pecific
  M easurable
  A ppropriate
  R ealistic
  T ime bound

Behaviour 1: Local authorities and medical professionals are committed to NID as an Afghan priority.

- Objective - 1: By the end of 2001, local authorities in 90% of the districts of Afghanistan provide resources (transport, human resources, security facilities, cease-fire arrangements - as appropriate) during NIDs.
- Indicator: percentage of districts where local authorities have provided one or more of the resources described above.
- Source/methodology: District Health Offices reports.
- Objective - 2: By the end of 2001, 100% of the medical professionals in curative practices in all districts of Afghanistan a) are involved in planning, implementation, M&E of NIDs; and b) inform their clients with <5 children about upcoming NIDs.
- Indicator: a) % of the medical professionals in curative practices who are involved in planning, M&E of NIDs; b) % who inform their clients with <5 children about upcoming NIDs.
- Source/methodology: a) Districts Health Offices reports; b) exit interviews with clients.

Behaviour 2: EPI/Polio service providers/health staff communicate effectively with parents/ caretakers.

- Objective -3: By the end of 2002, 100% of EPI/Polio service providers/health staff in all districts of Afghanistan a) inform and b) get positive feedback from parents/caretakers/women about the need to immunise children and women of CBA against immunisation preventable diseases.
- Indicators: a) % of service providers who inform parents/caretakers/ women & get positive feedback; b) % of parents/caretakers/women of CBA who, after contact with service providers, state that they have been informed and that they are convinced about the importance of getting children/women of CBA immunised.
- Source/methodology: Structured observations; interviews with parents/caretakers/women after contact with service providers.

Behaviour 3: Parents/Caretakers bring their children for immunisation

- Objective - 4: By the end of 2002, 60% of parents/caretakers in all districts of Afghanistan will bring their children <1 to be fully immunised.
- Indicator: % of <1 children vaccinated with antigens (BCG, DPT, OPV, measles).
- Source/methodology: Routine reporting; EPI coverage survey.

- Objective - 5: 100% of parents/caretakers in all districts of Afghanistan will bring their children <5 to be vaccinated against polio during October 2000 NIDs and all subsequent NIDs.
- Indicator: % of <5 vaccinated during October 2000 NID and following NIDs; number of polio AFP cases reported.
- Source/methodology: Health system reporting; sentinel surveillance reports.

- Objective - 6: 40% of women of child bearing age in all districts of Afghanistan vaccinated against TT by end of 2002.
- Indicator: % of women of CBA vaccinated with TTV 2.
- Source/methodology: Routine reporting; EPI coverage survey.

- Objective - 7: By the end of 2001, 100% of parents/caretakers in all districts of Afghanistan will be able to state a) at least one vaccination benefit and b) number of routine immunisation contacts needed to get children fully immunised.
- Indicator: % of parents/caretakers who can state one vaccination benefit and number of immunisation contacts needed to complete routine immunisation.
- Source/methodology: sample survey.

Behaviour 4: Communities are involved in NIDs and AFP Surveillance.

- Objective - 8: By the 3rd NID in 2000, 90% of districts will have community leaders involved in NIDs district level planning meeting by a) providing information on number of families; b) mapping; c) selection of itineraries; d) selection of volunteers.
- Indicator: % of districts that have community leaders involved in a), b), c) and d) above.
- Source/methodology: Review of meeting records; reports from Districts' Health authorities.

- Objective - 9: By June 2002, 100% parents/caretakers in 130 districts of Afghanistan will bring their children <15 with AFP symptoms to the nearest sentinel site within 24 hours of onset.
- Indicator: non-polio AFP = 1/100,000
- Source/methodology: Health system reporting; sentinel sites reporting.

Day 4: Communication Strategy, Objectives, Activities and Monitoring and Evaluation Plan 2000-2002

Strategic Plan: objectives 1, 2, 3

Objectives	Strategy	Approach	Activities	Responsible	When	
1: By the end of 2001, local authorities in 90% of the districts of Afghanistan provide resources (transport, human resources, security facilities, cease-fire arrangements - as appropriate) during NIDs.	Advocacy with local authorities	Individual meetings Joint briefings	Meetings with authorities Joint briefings with district administration	MoPh (regional) UNICEF-ACO/ WHO-Isb	August	
2: By the end of 2001, 100% of the medical professionals in curative practices in all districts of Afghanistan a) are involved in planning, implementation, M&E of NIDs; and b) inform their clients with <5 children about upcoming NIDs.	Social mobilisation	Group meetings Use of radio	Develop materials Organise orientation meetings		August	
3: By the end of 2002, 100% of EPI/Polio service providers/ health staff in all districts of Afghanistan a) inform and b) get positive feedback from parents/ care-takers/women about the need to immunise children and women of CBA against immunisation preventable diseases.	Programme communication	Mass media IEC materials Training of health workers Advocate for more female vaccinators	Adapt existing training materials Organise training for 1,000 vaccinators and other health workers Monitor training Use mass media	REMT UNICEF/ACO WHO-Islamabad	Aug/Sept	

Monitoring Plan: objectives 1, 2, 3

Objective	Activities	Indicators	Method	Time-frame	Locality	Responsible
1: By the end of 2001, local authorities in 90% of the districts of Afghanistan provide resources (transport, human resources, security facilities, cease-fire arrangements – as appropriate) during NIDs.	31 meetings with 31 Walis. 31 joint briefings for 66 DA/DHOs.	No. of meetings held No. of briefings held No. of participants attended Notification issued Human/Financial resources provided	Follow-up reports	Every six months	Provincial capitals Districts centres Health centres	All REMT 8 REMTs UNICEF Reg. Offices WHO MoPH/8 rep.
2: By the end of 2001, 100% of the medical professionals in curative practices in all districts of Afghanistan a) are involved in planning, implementation, M&E of NIDs; and b) inform their clients with <5 children about upcoming NIDs.	Develop leaflet for medical professionals 62 orientations for medical professionals (female separate)	No. of copies printed/shared No. of orientations held Participation of medical professionals visible in planning, implementation, M&E of NIDs. % of parents informed about NIDs by medical professionals	- Follow-up - Monitoring visits - Report			MoPH at central level UNICEF ACO WHO
3: By the end of 2002, 100% of EPI/Polio service providers/ health staff in all districts of Afghanistan a) inform and b) get positive feedback from parents/ care-takers/women about the need to immunise children and women of CBA against immunisation preventable diseases.	- Adaptation of training materials and 2,000 copies to be printed - 34 training for service providers (female separate) - monitoring visits - contract/agreement with radio for broadcasting training package - provide incentives as motivators to EPI service providers in form of e.g. additional payment/inter-regional competitions/certificates, appreciation letters.	No. of copies printed No. of trainings held No. of visits undertaken and reports shared No. of radio programmes % of parents/caretakers state that this issue listened to -Radio programmes & bring children for immunisation - Incentive scheme preferred and implemented -Increased % of EPI coverage	Follow-up training plan Reports on training Monitoring reports Transmission certificate Interviews with P/C	Every six months	* National capital * Provincial capital * At sites * All regions/ provinces	TCC at central level REMT/PEMT/all regions/provinces

Evaluation Plan: objectives 1, 2, 3

Objective	Indicator	Source/Methodology	Time-frame	Responsible
1: By the end of 2001, local authorities in 90% of the districts of Afghanistan provide resources (transport, human resources, security facilities, cease-fire arrangements – as appropriate) during NIDs.	See indicators	Integrated evaluation of communication strategy plan	January 2003	3rd party
2: By the end of 2001, 100% of the medical professionals in curative practices in all districts of Afghanistan a) are involved in planning, implementation, M&E of NIDs; and b) inform their clients with <5 children about upcoming NIDs.	Same	Same	Same	
3: By the end of 2002, 100% of EPI/Polio service providers/ health staff in all districts of Afghanistan a) inform and b) get positive feedback from parents/ care-takers/women about the need to immunise children and women of CBA against immunisation preventable diseases.	Same	Same	Same	



Planning Workshop

on

Communication for Polio Eradication, EPI and Surveillance

in

Afghanistan



Workshop Report

15-19 May 2000, Pearl Continental, Peshawar

Strategy Plan: objectives 4, 5, 6

Objectives	Indicators	Overall strategy	Strategy/Activities	Activities	Time	Responsibility
Objective # 4: by end of 2002 60 % of parents/caretakers in all districts will bring their children < 1 year fully immunized	% of children under-1 fully immunised	Social mobilisation Program Communication	Training vaccinators Social mobilizers Health workers Volunteers Religious leaders Authorities Mass media IPC Group communication	5,310 outreach focal points organise CHB Conduct training for 1000 vaccinators + 100 Soc. mobilizers Orientation for local authorities Developing of SM materials (Posters ; leaflets; banners) Develop training materials	- 4th Quarter 2000	MoPH, UNICEF, WHO, NGOs, community (volunteers) MoPH; UNICEF; WHO; NGOs and comm.
Objective # 5 100 % of parents/ caretakers in all districts of Afghanistan will bring their children <5year to be vaccinated against Polio during Oct 2000 NIDs and all subsequent NIDs.	% of Under-5 vaccinated during October 2001 number of AFP cases reported	Social mobilisation Program communication	District coordinator Medical professionals Community leaders See Objective 4	- meetings/ workshop - public gathering - parade - Material develop	July 2000 Sep 2001 Oct 2001 July 2000- Sep. 2000	MoPH; UNICEF; NGOs; WHO communities Vice and virtue UNICEF MoPH WHO
Objective # 6 40 % of women of CBA in all districts of Afghanistan vaccinated against TT2 by the end of 2002	% of CBA women vaccinated with TT2	Social mobilisation Program communication	Health education during vaccine session by vaccinators; health workers and community members Radio IPC Group communication	-Health Education training for health workers - Health education for communities -Message dissemination	Jan 2001 Ongoing Ongoing	MoPH, WHO UNICEF, NGOs MoPH, NGOs, community

Monitoring Plan: objectives 4, 5, 6

Objective	Activity	Indicator / Process / impact	Method	Where	Who	When
Objective 4: By the end of 2002 60 % of parents/care-takers in all districts of Afghanistan will bring their children < 1 year to be fully immunized.	Work with women groups Work with community leaders Orientation for community members Development of SM materials (Posters; leaflets; banners)	No. of workshops conducted No. of oriented comm. leaders No. of materials (Posters; leaflets) developed/distributed (In all districts) No. of community meetings held No. of community members informed/oriented No. of copies printed and distributed No. of women groups informed/ oriented No. of parents/caretakers immunised their kids No. of mothers know immunisation control schedule No. of mothers know benefits/& attitude change for immunisation	Monitoring visit - (Observation) - by MoPH, UNICEF and WHO	In all districts REMTs	REMTs	
Objective 5: 100% of parents/ care-takers in all district bring children Under-5 to be vaccinated during the NIDs	-meetings/ workshops public gatherings parades Material development (posters, leaflets, pamphlets)		Monitoring material distributed every where	In all REMTs	REMTs	
Objective 6: 40 % of women of CBA in all districts of Afghanistan vaccinated against TT2 by end of 2002.	- Health Education training for health workers -Health education orientation for communities -Message dissemination		Monitoring visit Interview of caretakers Focus groups discussions Review of reports	In all districts REMTs	REMTs	

Evaluation plan: objectives 4, 5, 6

Objectives	Indicators	Source	When	Who
Objective # 4: by end of 2002 60 % of parents/caretakers will bring their children < 1yr to be fully immunized.	% of children < 1year to be fully immunized	- Routine reporting - EPI coverage surveys	Final: Jan 2003	MoPH; UNICEF WHO and NGOs
Objective # 5 100 % of parents/ caretakers in all districts of Afghanistan will bring their children < 5yr to be vaccinated against Polio during Oct 2001 NIDs and all subsequent NIDs.	% of <5 year children vaccinated during Oct 2001 NIDs % of Polio AFP cases reported	Health system reporting : sentinel surveillance report	Nov 2001	MoPH; WHO :UNICEF and NGOs
Objective # 6 40 % of women of CBA in all disticts of Afghanistan vaccinated against TT2 by the end of 2002	% of women of CBA have taken TT2 vaccine	Routine reporting EPI coverage survey	Final: Jan 2003	MoPH: UNICEF; WHO and NGOs

Strategy Plan: objectives 7, 8, 9

Objectives	Strategy	Strategic approach	Activities	Time frame	Responsible
Objective 7: By the end of 2001, 100% of parents/caretakers in all districts of Afghanistan will be able to state at least one immunisation benefit and number of immunisation contacts needed to get children fully immunised.	Programme Communication Social mobilisation	Inter-personal communication (one-to-one and group) Mass media	1. 500 educational sessions per working day through 441 fixed centres and outreach sites in all districts of Afghanistan through fixed, outreach/mobile approach. 2. 1,000 home visits sessions per day in all of Afghanistan through CHW, TBAs and VHWs. 3. 4,000 orientation meetings with care takers through districts gatherings by June 2001 by EPI Supervisors and District Health Officers.	Starting from 3rd quarter 2000	Vaccinators, Health Educators, TBAs, VHWs, District Health staff, PEMT, REMT
Objectives 8: By the third NID 2000, 90% of districts in Afghanistan will have community leaders involved in NIDs district level planning	Social mobilisation	One-to-one group	1,326 orientation sessions/meetings with district authorities by District Health Coordinators.	Between 2nd and 3rd NIDs 2000	District Health Coordinator, Supervisor PEMT, REMT
Objectives 9: By June 2002, 100% parents/caretakers in 130 districts of Afghanistan will bring their <15 children with AFP to sentinel sites within 24 hours of onset.	Programme Communication Social mobilistaion	Inter-personal communication (one-to-one and group) Mass media	5,000 home-visiting trips to explain 3-lay definition of AFP signs/symptoms to parents/caretakers.	Starting from 3rd quarter 2000	Vaccinators, H.Educators, TBAs, VHWs, District Health Staff, PEMT, REMT, Parents/ caretakers

Monitoring Plan: objectives 7, 8 and 9

Objective	Activity	Indicators	Method	Where	Who	When
7. By the end of 2001, 100% of parents/caretakers in all districts will be able to state one benefit of vaccinations and no of vaccinations needed for children for full immunization	500 educational sessions per day with parents/ caretakers through 441 EPI fixed centers and mobile or outreach sites in all districts 1000 home visits per day in all districts (by CHW, TBA and VHS's) 4000 orientation meetings with caretakers through district gatherings by June 2001 (by EPI supervisors and District Health Officers)	No of sessions % of parents/ caretakers who can tell at least one benefit of vaccinations % of parents/ caretakers who know no of vaccinations needed	Sample survey Supervision visits Reports Interviews	Fixed centers Communities Communities Communities	MPOH WHO UNICEF NGO's District Health Officers EPI supervisors District Health Officers EPI Officers	June-Dec 2000 Aug-Dec 2000 Aug 2000- Jun 2001
8. By the end of the 3rd round of NIDs in 2000: in 90% of all districts communities will be involved in NIDs district level planning	1328 orientation meetings and one to one meetings with community elders and district authorities	- No. of sessions - No. of micro-plans	Visit reports Micro plans Review of meeting records Reports from district health authorities	Districts	WHO sub office NGOs UNICEF sub-off District Health Coordinators	July-August 2000
9. By June 2002 in 130 districts 100 % of parents/caretakers will bring <15 years children with AFP to sentinel sites within 24 hours of onset	5000 trips to explain 3 signs of AFP	Number of AFP cases reported % of parents/ caretakers who can tell 3 signs of AFP	Health system reports Sentinel sites reports Interviews	Sentinel sites Communities	WHO sub office NGOs PEMT REMT	Jan-December 2001

Evaluation Plan: objectives 7, 8 and 9

Objective	Indicators	Method	Where	Who	When
7. By the end of 2001, 100% of parents/caretakers in all districts will be able to state one benefit of vaccinations and no of vaccinations needed for children for full immunisation	% of parents/ caretakers who can tell at least one benefit of vaccinations % of parents/ caretakers who know no of vaccinations needed	Sample survey	Fixed centers Communities	MPOH WHO UNICEF NGO's District Health Officers EPI supervisors	First quarter 2002
8. By the end of the 3rd round of NIDs in 2000: 90% of all districts will have community leaders involved in NID district level planning.	% of districts where community leaders are involved	Review of meeting records Reports from district health authorities	Districts	"	October 2000
9. By June 2002 in 130 districts 100 % of parents/ caretakers will report AFP cases within 24 hours of onset.	Number of AFP cases reported	Health system reports Sentinel sites reports	Sentinel sites	"	2002

2. **Review of messages and materials:**

Message should be:
- clear, short, simple
- culturally acceptable
- appropriate language
- indicate what action is needed
- indicate when action should take place
- be clear for whom the message is meant

Approaches can be:
- informative
- educative
- persuasive
- entertaining

Tone can be:
- positive or negative
- rational or emotional
- collective or individual
- humorous or serious
- monovalent or bivalent
- director or indirect

Message Concepts:

Target audience	**Behaviour to promote**	**Factors influencing adoption**	**Message and concept**	**Approach**	**Tone**
Local authorities	Support NIDs and provide financial and human resources	Notification; positive competition; public recognition; pride in achievements	Presentation on global situation Afghan fact sheet; religious obligation	Informing Educating Persuading	Positive Direct Rational
Medial professionals	Participate in NIDs	Orientation meetings Motivation	Moral obligation of the medical professionals	Persuading	Positive Emotional Serious
Service providers	Inform parents get positive feedback	Motivating packages; use of mass media	Training materials Press releases	Informing Educating	Positive Collective Rational
Parents and caretakers (for immunisation)	Bring children for immunisation	Benefits of immunisation, religion	Immunisation will save lives	Informing Educating	Rational and monovalent
Parents and caretakers (NIDs)	100% coverage of NIDs	Benefits of OPV Polio causes disability Statistics on disability	Message of NIDs: prevent diseases, saves lives, & prevents disability	Educating Presuading	Negative Serious Direct
CBA women (TT2 vaccination)	Women come for TT	Appeal by local authorities Saves lives of children/mothers	Prevents disability and promote healthy children	Informing Educating Persuading	Positive Negative

1. Urban elite 2. Nomadic people 3. Isolated areas 4. Conflict areas 5. Children in urban slums 6. Ethnic religious minorities 7. Children with disabilities 8. Poorest people 9. New-borns	Parents and caretakers bring children for immunisation Communities are involved in NIDs	Security Socio-cultural Socio-economic status Knowledge level on child and health care Existing communication channels Access to communication channels	Includes every child/all children	1. Persuasive 2. Informative/ educative/ persuasive 3. Persuasive/ informative 4. Informative persuasive educative entertaining 5. Same as 4 6. Same as 4 7. Informative/ educative/ persuasive 8. Same as 7 9. Same as 7	

Note:
- more female vaccinators are needed
- special messages needed for CBA women
- special messages needed for men about importance of health of mothers
- use can be made of the role of influential women in villages
- UNICEF and WHO can share international experiences with other partners

3. Additional research:

Two types of research can be distinguished: qualitative and quantitative. Combinations of the two types are often used. Examples of the two are following:

Qualitative	**Quantitative**
Focus group discussion	Knowledge, attitude and practice survey (KAP)
Structured observation	Sample survey
In depth interview	Records review
Exit interview	Demographic health survey
Key informant interview	Intercept interview
Participatory rapid appraisal	Census
Ethnographic research	

Several issues for further research were mentioned during the workshop:
- relation between illiteracy and immunization coverage
- boys/girls equity
- coverage new born babies
- neglect of disabled children
- effectiveness of radio programmes
- use of news papers
- religious and ethnic minorities.

It was noted that UNICEF is already planning to evaluate the effectiveness of the BBC program Afghan Education Drama "New home, new life".

The other areas as mentioned above for further research, could also be taken up by interested partners. At this stage , taken into account limited resources (human and financial) and the timing, the workshop participants decided that priority should be given to research of:

1. effective communication strategies/activities/messages and channels for illiterate people (in particular for the hard to reach groups, like nomadic people, people living in remote areas, people living in conflict areas, disabled children, new borns, very poor etc)
2. Encouraging factors to ensure that new born babies are immunised in time.

Research priorities	Action/method	Responsible organisation	Timing	Who funds the research
Communication strategy for illiterate people	Review existing research/ results Research on hard to reach groups Research on families/ individuals who have not been immunised Community based surveys KAP surveys Interviews Group discussions	MoPH UNICEF WHO NGOs	Start preparations (scope for research and TOR) July 2000 Research results should be available by end 2000	??
New borns: encouraging factors to promote immunisation	See above	See above	See above	??

Note:
- UNICEF will investigate to what extent relevant questions related to the above research priorities can be incorporated in the MICS survey for Afghanistan.
- Possibly the two above mentioned research issues can be combined

4. Training Plan:

This plan needs to be developed in 2000.
During the workshop sessions it was not defined that who will be responsible for what and when.
UNICEF is requested to develop a proposal to be finalized in consultation with partners.

5. Dissemination Plan:

This plan needs to be developed in 2000.
During the workshop session it was not defined yet who will be responsible for what and when.
UNICEF is requested to develop a proposal, to be finalized in consultation with partners.

Day 5

1. Feedback Day 4

The participants appreciated the progress which was made during the workshop. Good discussions took place. It was noted that there is a good mix of people present with different backgrounds and experiences. The experiences of the participants dealing with programs in Pakistan were also very much appreciated. The suggestion was made that in the future also Afghan participants are invited to Pakistan workshops, to share their experiences (UNICEF, WHO and NGO's please take note).
The facilitators will provide the participants with a draft workshop report on the last day of the workshop. The final reports will be distributed as soon as possible.
Certificates will also be distributed on the last day, more formal certificates will be distributed later.

2. Remarks by the UNICEF Representative Afghanistan Country Office, Louis- Georges Arsenault

UNICEF supports, together with WHO and many other partners, the global objectives on polio eradication and full immunization of children and CBA women. Within this framework UNICEF is honored to be able to support and organize this workshop. The main purpose of this workshop is to improve our planning and communication strategies which will further strengthen and enhance the Polio/NIDs initiatives. UNICEF allocates a considerable percentage of its budget and human resources for the polio/NIDs initiative. Therefore UNICEF considers this workshop extremely important.

The communication model can be used for other sectors/activities as well. It is good to see present at the workshop so many familiar faces of friends and colleagues who work in Afghanistan and Pakistan. As this is the fourth day of the workshop, it can be noted that a lot of progress has been made. Looking at the program and the outputs so far, the objectives of the workshop seem achievable, and the concerns are being taken into account.

The UNICEF Representative shared one concern which is relevant to all partners involved in the Polio/NIDs initiative. The outcome of the May NIDs indicated that there are many areas where far over 100 % coverage was reached. This is not realistic and indicates the at the estimates used were too low. This needs to be taken into account while planning the next round. More realistic figures, based on the May 2000 round will need to be used.

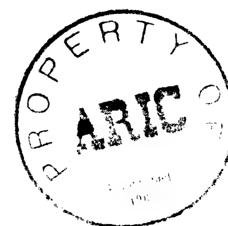
3. Implementing the Communication Plan/Action Plan 2000:

Setting priorities in action and work plans

The following selection criteria were identified to set priorities when priority actions conflict.

1. Importance
2. Relevance
3. Related to and supportive of objectives to be achieved
4. Direct impact/quick results
5. Accessible

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6. Realistic/achievable
7. Simple
8. Availability of funds/budget
9. Cost effective
10. Culturally acceptable
11. Needs based

Setting priorities for the Action Plan 2000

This item on the agenda proved difficult. Some participants wondered how to incorporate the workshop plans in their own work plans. Some tried to make a detailed planning for 2000 but the plans seemed too ambitious. For example it can not be expected that in the period May 22-June 2 (two weeks between the end of the workshop and the next NIDs round) much additional activities can be planned, nor can additional messages be developed nor additional materials be produced.

Therefore the following framework is suggested which needs to be updated and finalised and approved by the relevant organisations.

Objective	Activity	Responsible	When in 2000	Additional funding required
Training plan	To be developed	UNICEF-ACO/Health	July	No
Dissemination Plan	To be developed	UNICEF-ACO/IC Sec.	July	No
Objective 1: Local authorities provide resources	Develop messages	UNICEF/ACO/ Health	July	No
" " "	Pretest and print messages	UNICEF/ACO/ ICSEC	August	No
" " "	Develop materials for advocacy	JTCC	July	?
" " "	Print materials for advocacy	.....	August	Yes
" " "	Develop policy/budget for incentives	JTCC plus concerned NGO's	July	Yes
" " "	Individual and joint briefings of local authorities	MoPH/REMT UNICEF/ACI/Health WHO Islamabad	August	
Objective 2: Service providers/health staff communicate effectively with parents/c-takers	Advocacy meetings with sub offices See also objective 6	PEMT REMT WHO/sub offices UNICEF/sub offices	August	No
Objective 3: Service providers /health staff inform effectively parents/women/care-takers about need immunization children and CBA women	See objective 4	See objective 4	See obj.4 September August	 No No
Objective 4: Parent/care-takers bring children under-1 year for immunization	Develop messages on NID	PHC Dept. of MOPH WHO/Islamabad UNICEF/ACO/Health CDAP-Info Section SC/US-Health Dept.	---	No
" " "	Pre test messages	See above	July	Yes

" " "	Finalize and print messages	See above	August	Yes
" " "	Revise/develop training materials for health staff/vaccinators/volunteers	WGO/IBD-Health UNICEF/ACO/Health SC-US, Mazar	July	
" " "	Training for health staff/vaccinators/volunteers	22 PEMTs, 5 REMTs 8 Health Dept WHO sub-office UNICEF sub-office	August	
" " "	Orientation for local authorities	?	August	
Objective 5: Parents/care-takers bring children for polio immunisation	See objective 4			
Objective 6: CBA women vaccinated against TT	1. Training health workers 2. Health education in communities and message dissemination	Dept PHC, MOPH WHO/sub-office UNICEF/sub-office Health Net Int. Ibn Sina	1. August 2. Sept-Dec	
Objective 7: parents/care-takers can state benefit of immunisa-tion and no vaccinations required by children	Community health meetings	22 PEMT and WES of MOPH 8 Health Depts. WHO and UNICEF	August	
" " "	500 educational sessions per working day with parents	5 REMT UNICEF sub-office WHO sub-office NGO's	June-December	
" " "	1000 home visits per day 4000 orientation meetings	Comm health workers (TBA's, volunteers, NGO's: SCA, IFRC, SC/US, ACF, MSF, Ibn Sina, HNI, NAC) WHO/Jalalabad REMT, PEMT	Aug-Dec	
Objective 8: Community leaders involved in planning	1328 orientation sessions with district authorities and community leaders.	District Health Coordinators WHO sub-office UNICEF sub-offices NGO's	July-august	
Objective 9: Parents/care-takers report AFP	5000 trips to explain AFP signs	WHO sub-office NGO; PEMT REMT	Jan-Dec 2001	
Research	New borns Review existing research, do additional community based surveys, KAP surveys, interviews, group discussions	MOPH UNICEF/ACO/Health WHO ISB NGO's	July-Dec	
" " "	Address illiteracy issues See above Research on hard to reach Research on families/ individuals who were not immunized	See above on new borns	July-Dec	
Monitoring	See monitoring plan			
Evaluation	See evaluation plan			

4. Evaluation

The workshop participants filled in the evaluation forms. Overall it can be considered that the objectives of the workshop were met, and according to quite a few participants it went even beyond. Strategies for the hard-to-reach clearly still need to be worked out. The detailed outcome of the evaluation is described below.

I. Have the agreed objectives of the workshop been met?

1. Develop common understanding of communication planning process and apply it to Afghanistan context
a) Yes and went beyond: 9
b) Met: 13
c) Not completely: 3
d) Not met: 0

Comments:
a)We learned new things, shared experiences, non-communication specialists were empowered, wonderful workshop.
b)We shared experiences to make it more realistic, objective oriented workshop
c) Facts were based on forecasting and not on reality.

<u>2. To develop a strategic plan for communication for NIDs, Routine EPI and Surveilance</u>
a) Yes and went beyond: 7
b) Met: 14
c) Not completely: 4
d) Not met: 0

Comments
a) It will help to make a realistic plan for NIDs
b) The plan needs further development at central and regional levels.
There was not always enough time for group work
Lack of data is a problem.
The participation of UNCEF Pakistan was very useful
c) More work needed to develop a plan
WHO-Islamabad should have participated (in particular on AFP and surveillance)

<u>3. Identify specific strategies to reach the hard to reach</u>
a) Yes and went beyond: 5
b) Met: 8
c) Not completely: 10
d) Not met : 2

Comments:
a) (no comments)
b) Still we have to think more about how to reach those groups

d) We did not produce a specific strategy
   No detailed discussions took place on this, no channels identified yet.
e) (no comments)

II. Where your expectations fulfilled

a) Yes and went beyond: 10
b) Fulfilled: 12
c) Somewhat but not completely: 1
d) Not: 1

Comments:

a) I am in a better position now to think about communication, also in other sector. Good facilitator.
b) The best workshop ever, in terms of management and materials covered (this person participated in 20 other workshops)
c) Not all expectations were checked at the end
d) Expected to learn more about communication and planning skills. A bit confusing.

III. What happened to your concerns/Have your concerns materialized

Note : As there were two questions and the list of possible answers confusing, some misunderstanding in the replies occurred.

a) Not at all: 18
b) Partially: 3
c) Yes: 4

IV. Two additional things....

<u>1) Two additional things you gained during the workshop</u>

Communication skills of participants.
Participatory work/group work
Conduct training in hard-to-convince environment
Process of developing a strategy
Monitoring and evaluation plan
Participation of different agencies
How to plan a workshop
Plan specific objectives and activities
How to be patient and approachable
Insight in various problems of EPI
Importance of research
Experiences of different countries
Surveillance and AFP
To know each other and to be able to keep in touch in the future.

<u>2) What would you have liked to be done differently during this workshop?</u>

Nothing
More role plays

Use of audio-visuals
Encourage silent participants more
Cut lengthy discussions short
Earlier distribution of materials
Include participants from other countries in the region
Translate materials
More communication between head and country offices before the workshop
More on development of messages
Two facilitators to speak more clearly and loudly, and to be conclusive when the session ends.

5. Closure and distribution of draft report and certificates

On behalf of all participants, Mrs Jet van der Gaag thanked the facilitator Mrs Silvia Luciani for her wonderful work as facilitator. The evaluation clearly showed how much she is appreciated by the participants. All participants were thanked for sharing their experiences and their very active participation. It was recalled that the workshop indeed had been an active planning workshop, clearly focussing on the objectives as defined during the first session. Mrs van der Gaag wished all participants good luck with the follow up and the implementations of the proposed actions, and a safe journey home.

All participants received copies of the presentations during the workshop and the draft report. The final version of the report will be finalized and distributed by UNICEF.

All participants received a certificate of participation in the workshop. A plastified version of the certificate will be distributed by UNICEF after the workshop.

6. Indicators to determine the success of the follow up of the workshop

The workshop was successful, taking into account the comments and the evaluation forms of the participants (see Day 5, par. 4). To be able to review whether the workshop is successful in terms of making use of the learning experience, and achieving the ultimate goals (polio eradication, full immunisation etc), the follow up of the workshop by the participants and the involved organisations needs to be carefully planned and monitored.

The following steps are required:
1. Finalize and approve action plan and budget 2000 (See Day 5, par.3): by Health sector, UNICEF, WHO and relevant NGO's
2. Prepare and approve action plan and budget 2001: by Health sector, UNICEF, WHO and relevant NGO's
3. UNICEF will need to monitor closely the follow up. ACO staff (Survival section) will spend at least 10 days per month on this in close collaboration with WHO and the sub offices.

Some indicators are developed: These will be updated and finalized by UNICEF-ACO/Survival section, based upon the objectives of the workshop.
a. Apply the communication model to Afghanistan:

- Communication work plans (based on communication model) for health , education and other sectors
- Activities implemented according to work plans
- Time / budget spent on communication work plan
- Behaviour change according to indicators to be included in monitoring and evaluation plan of work plan

b. Develop an action plan for polio eradication, EPI and surveillance
   - Final action plan per organisation and/or individual for 2000 and 2001 (see Day 5, par. 3)
   - Activities implemented according to action plans
   - Time/budget spent on action plan
   - See indicators in M/E plan (see Day 4, Para 1)

c. Implement specific strategies and activities to reach the hard to reach target audiences, communities, families and individuals:
   - specific strategies and action plans/budgets developed and activities implemented (see Day 3, Para 2).

- Communication work plans (based on communication model) for health , education and other sectors
- Activities implemented according to work plans
- Time / budget spent on communication work plan
- Behaviour change according to indicators to be included in monitoring and evaluation plan of work plan

b. Develop an action plan for polio eradication, EPI and surveillance
   - Final action plan per organisation and/or individual for 2000 and 2001 (see Day 5, par. 3)
   - Activities implemented according to action plans
   - Time/budget spent on action plan
   - See indicators in M/E plan (see Day 4, Para 1)

c. Implement specific strategies and activities to reach the hard to reach target audiences, communities, families and individuals:
   - specific strategies and action plans/budgets developed and activities implemented (see Day 3, Para 2).

Annexes

Final AGENDA

Planning Workshop
on
Communication for Polio Eradication, EPI and Surveillance in Afghanistan

15-19 May 2000, Hotel Pearl Continental, Peshawar

Monday, 15 May 2000

Time	Session	Notes:
08:30-09:00	Opening	
09:00-10:30	Introduction, expectations and objectives of the meeting Establishment of Feedback Committees	
10:30-10:45	Tea/coffee/refreshments	
10:45-11:15	What is Communication about?	
11:15-12:30	The Communication Planning Process	
12:30-14:00	Lunch	
14:00-15:30	Situation Assessment: Presentation on basic data and research results on polio/EPI & Surveillance in Afghanistan: issues, challenges & opportunities. (Chapter 3B)	
15:30-15:45	Tea/coffee/refreshments	
15:45-18:00	Problem analysis and statement (Chapter 3 C)	
18:00-18:30	Feedback Committee assessment	

Tuesday, 16 May 2000

Time	Session	Notes
08:00-08:15	Outcome feedback day-1	
08:15-08:30	Problem statement	
08:30-09:00	Introduction behavioural/non-behavioural causes	
09:00- 09:45	Group work: behavioural analysis	
09:45-10:30	Plenary behavioural analysis	
10:30-11:00	Tea/coffee/refreshments	
11:00-13:00	Plenary: behavioural analysis	
13:00-14:00	Lunch	
14:00-16:00	Participants/audience analysis	
16:00-16:15	Tea/coffee/refreshments	
16:15-17:30	Channel analysis	
17:30-18:00	Feedback Committee meets with facilitators	

Day -1

1. Opening:

Mr Aliu Bello (Head Survival programme UNICEF) opened the workshop on behalf of the UNICEF Representative. He welcomed all participants, and wished all a good and fruitful workshop. He highlighted the importance of the workshop, and hoped that it contributes to a complete eradication of polio and full immunisation coverage of Afghan children and women. He mentioned that this workshop provides a unique opportunity for participants with very different backgrounds (experts in communication, health, education, WES etc) and from various organisations (MoPH, RRD, NGO's, WHO, CDAP and UNICEF) to share their experiences. He expressed his sincere hope that this workshop will enable all to apply what will be learned, discussed and planned during this workshop, in their own working environment.

All workshop participants received the "Communication Handbook for Polio Eradication and Routine EPI" which will be used for the development of the strategies and action plans.

2. Objectives of the workshop as finalised by the Workshop participants:

- Get familiar with the good and bad experiences of a Communication Planning Model
- Apply the model and strategy to Afghanistan
- Develop an integrated and strategic communication action plan for polio eradication, EPI and Surveillance (2000-2002). Including workshop follow-up actions.
- Develop specific strategies and activities to reach the hard to reach target audiences, communities, families and individuals.

3. Participants' expectations:

- Learn more about communication (importance, means and type of communication)
- A strategy and an action plan for communication
- Action plan for our own areas
- Sharing experiences
- Strategy to reach the un-reached (illiterate people and those living in isolated/remote areas)
- Female involvement
- Get commitment from medical professionals
- Convince political authorities

4. Participants' concerns for the workshop and solutions:

Concerns	Solutions
- Make action plan	- Included in workshop programme
- How to use VIPP	- Help each other in group work
- Language barrier	- Translate for each other
- The workshop will be boring and less practical	- Include energisers and develop practical action plan
- No active participation	- Include sufficient group work
- Participants not on time/time management	- Respect timing
- Ambitious/unrealistic programme	- Use experiences and keep in mind

Wednesday, 17 May 2000

Time	Session	Notes
08:00-08:15	Feedback day-2, and set group norms	
08:15-09:30	Reaching the Hard to Reach (chapter 8)	
09:30-10:30	Select communication channels for audience/participants	
10:30-10:45	Tea/coffee/refreshments	
10:45-12:30	Continue previous session	
12:30-13:30	Lunch	
13:30-14:20	Objectives and indicators	
14:20-14:30	Energiser	
14:30- 17:00	Continue previous session	
17:00-17:15	Experiences of other countries	
17:15-17:30	Feedback Committee assessment	

Thursday, 18 May 2000

Time	Session	Notes
08:00-08:10	Feedback day-3	
08:10-08:30	Communication objectives and indicators (ch. 3C)	
08:30-11:00	Design strategic plan (chapter 3C)	
11:00-11:15	Tea/coffee/refreshments	
11:15-13:00	Review of messages/materials and list of criteria (chapter 3B, Chapter 4, annex 4)	
13:00-14:00	Lunch	
14:00-15:00	Do we need any additional research (chapter 9)	
15:00-16:00	Training and dissemination plan (chapter 3 D)	
16:00-16:15	Tea/coffee/refreshments	
16:15-18:00	Monitoring and evaluation plan (chapter 9)	
18:00-18:15	Feedback Committee assessment	

Friday, 19 May 2000

Time	Session	Notes
08:00-08:15	Feedback day-4	
08:15-09:45	Continue monitoring and evaluation plan	
09:45-10:30	Implementing the Communication Plan (chapter 5): - Link with the planned NIDs etc - Integrating new tasks into our own workplan - looking at other conflicting priorities	
10:30-10:45	Tea/coffee/refreshments	
10:45-11:30	Continue previous session	
11:30-12:00	Distribute evaluation questionnaire	
12:00-12:30	Results of evaluation questionnaire Presentation of certificates Closure	
12:30-14:00	Lunch	

Planning Workshop on Communication for Polio Eradication, EPI and Surveillance in Afghanistan
15-19 May 2000, Pearl Continental, Peshawar

Final list of Participants

No	Name	Title	Office	Signature
1	Dr Waheed	APO	UNICEF Mazar	
2	Dr Iqbal Shah		SC-US, Mazar	
3	Mr Hossain Nishat		REMT Mazar	
4	Dr Atta Mohammad Nazar	APO Survival (WES)	UNICEF Jalalabad	
5	Dr Asif (replaced Toorpaika)	MCH Officer	MoPH Ningarhar	
6	Dr Tajwar Naseri		REMT Manager, Eastern region	
7	Dr Ansari	APO Survival	UNICEF Kabul	
8	Dr Gula Khan	Manager	REMT Kabul	
9	Dr M Qasem Sharafmal	Health staff	GRRD Kabul	
10	Dr Aqa Mohammad Dost	EPI Manager	MoPH, Kabul	
11	Ms. R Fatema	Community Social Mobiliser	GRRD Kabul	
12	Mr Khalil Kakar	APO Survival	UNICEF Herat	
13	Dr Amiri	APO Survival	UNICEF Herat	
14	Dr G Rabbani Wardak	APO Survival	Kandahar Outpost	
15	Dr Rahmatullah	REMT Manager	Southern Region	
16	Dr Karim Fareghi	EPI Trainer	WHO (Kabul) Islamabad	
17	Mr Sahibjan Katawazi	Communication Officer	WHO (Kabul) Islamabad	
18	Mr Hayatullah Wahdat	Information Officer	UNCDAP, Peshawar	
19	Dr Imran Ravji	EPI/Polio Eradication	UNICEF Pakistan, Islamabad	
20	Mr Suleman Malik	Ass't Communication Officer	" " "	
21	Ms Riffat Sardar	Senior Education Officer	" " "	
22	Dr Sarwar Hemati	EPI Advisor	Swedish Committee for Afghanistan	
23	Mr. Sayed Nadir	EPI Officer	Ibn Sina	
24	Mr Ahmad Masoud	Ass't Communication Officer	UNICEF ACO	

Facilitators/Support Staff:

1	Ms Silvia Luciani	Trainer	UNICEF NYHQ
2	Ms Jet van der Gaag	Consultant	UNICEF ACO
3	Mr Aliu Bello	Health Officer	" "
4	Dr Farid Bazger	Facilitator	Orphans, Refugees & Aid
5	Mr Asghar Ali	Information Assistant	UNICEF ACO

Overview of EPI in Afghanistan

Aliu Bello's Presentation

EPI Policy/Strategy

* The programme focuses on children under one year of age to receive different vaccines before their first birthday.
* Immunisation schedule:

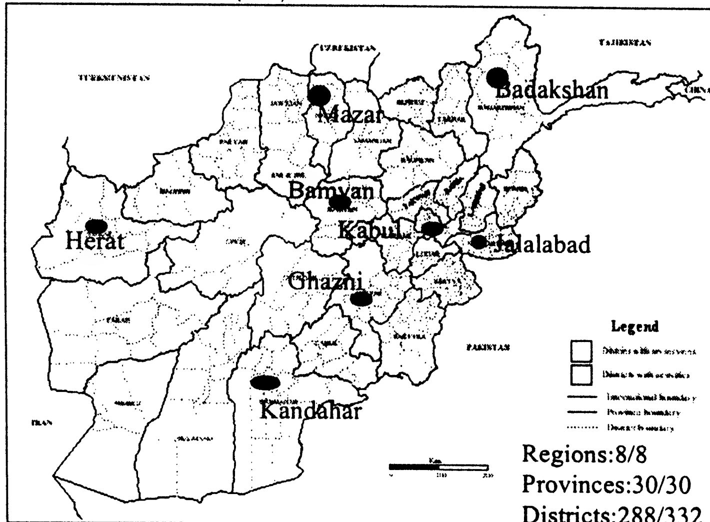
1st	at birth	BCG
2nd	6 weeks	DPT1, OPV1
3rd	after 1 month	DPT, OPV2
4th	after 1 month	DPT3, OPV3
5th	Nine months	Measles

* Women in child bearing age are also vaccinated against tetanus:

TT1	First contact, or as early as possible during pregnancy
TT2	One month after TT1
TT3	6 months after TT2
TT4	one year after TT3
TT5	one year after TT4

Polio Eradication:
Supplementary OPV given to children under-5 years of age through NIDs and Sub-NIDs

Overall Strategy:
* "EPI is the mother of PEI"
* Combination of fixed centres and outreach sites
* Special approach to remote and difficult to reach areas
* Acceleration campaign in selected high risk areas



Infrastructure of EPI in Afghanistan

I - Vaccine storage facilities:

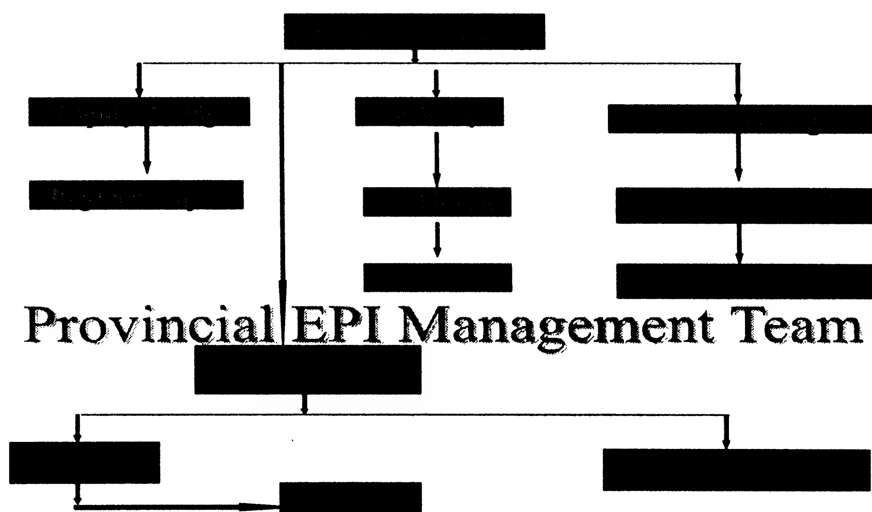
a. One Central cold room
b. Five Regional cold rooms
c. Twenty three Provincial cold rooms
d. Four Hundred forty one Fixed centers

II – Cold Chain Equipment

a. One hundred Ninety ILRs and chest freezers
b. Fifty ice pack freezers
c. One hundred twenty Sibir/RCW42 refrigerators
d. Thirty five generators
e. Sufficient quantities of cold boxes, vaccine carriers and ice packs

Manpower Strength for Routine EPI in Afghanistan 1999:

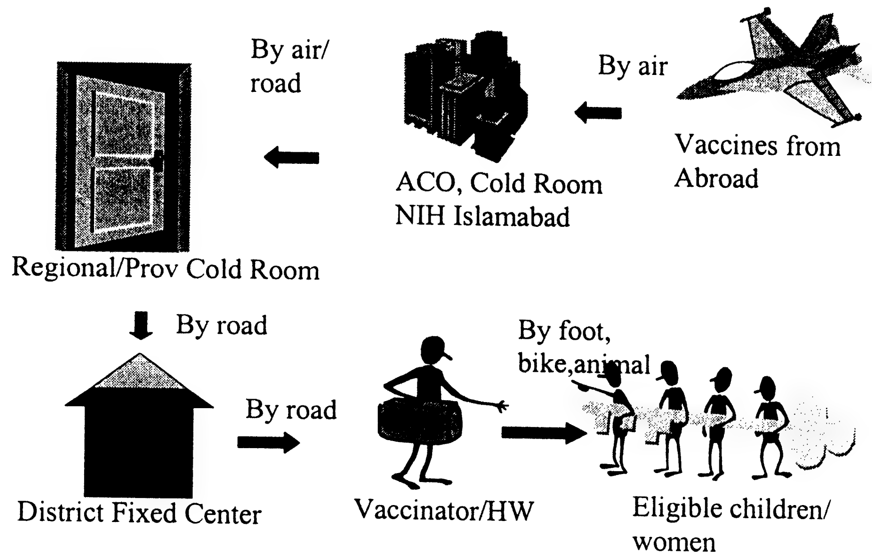
1. REMT/PEMT Manager---------------------- 32
2. Supervisors----------------------------------- 23
3. Cold Chain Staff----------------------------- 37
4. Vaccinators/Health Workers--------------- 990
   - Male vaccinators--------------------------- 825
   - Female vaccinators------------------------ 165



EPI Coverage 1997-99 in Afghanistan
(Routine Reporting)

Antigen	**1997**	**1998**	**1999**
BCG	66%	46%	48%
DPT/OPV-3	45%	37%	36%
Measles	57%	40%	41%
TT2 (CBA Women)	11%	11%	18%

COLD CHAIN FOR AFG VACCINES



Global Strategies for polio eradication

- High routine OPV immunization coverage
- Conducting quality NIDs,
- Establishing effective AFP surveillance,
- Mopping up immunization
- Experience of Laos and Cambodia:
    - Both were war affected countries,
    - No health infrastructure,
    - Low routine immunization coverage,
    - Quality NIDs twice a year for two years, 96-97,
    - Good surveillance system
    - No Polio since 1997

Polio Eradication Strategy for Afghanistan:
Current Status of NIDs:

- Afghanistan is now one of the 14 most important polio reservoir countries in conflict. The examples above demonstrat that polio eradication is feasible.
- MICs/NIDs have been conducted since 1995 during low transmission seasons (Oct-March) with coverage ranging from 80% (in 1998) and 95% (in Oct 1999) of children under-5 years.
- Sub-NIDs in border districts with Iran and Pakistan.
- Four rounds of NIDs conducted in 1999 (May/June/Oct/Nov)
- Four more rounds planned in 2000 (May/Jun/Oct/ Nov)
- 4 or 5 rounds planned for 2001 in addition to mopping up and sub-NIDs.

Status of AFP Surveillance in Afghanistan (source: WHO data April 2000)

- AFP surveillance established since September 1997
- 86 sentinel sites in 44 districts out of 330
- The system has so far detected 520 AFP cases of which 237 were confirmed polio (Sept 1997 - April 2000)
- Plan to expand to 200 sites in 2001 covering 130 districts
- Need to further improve the performance indicators, provide more supplies and equipment, and establish community based referral points.

Key Findings from Assessment and Studies in Afghanistan:

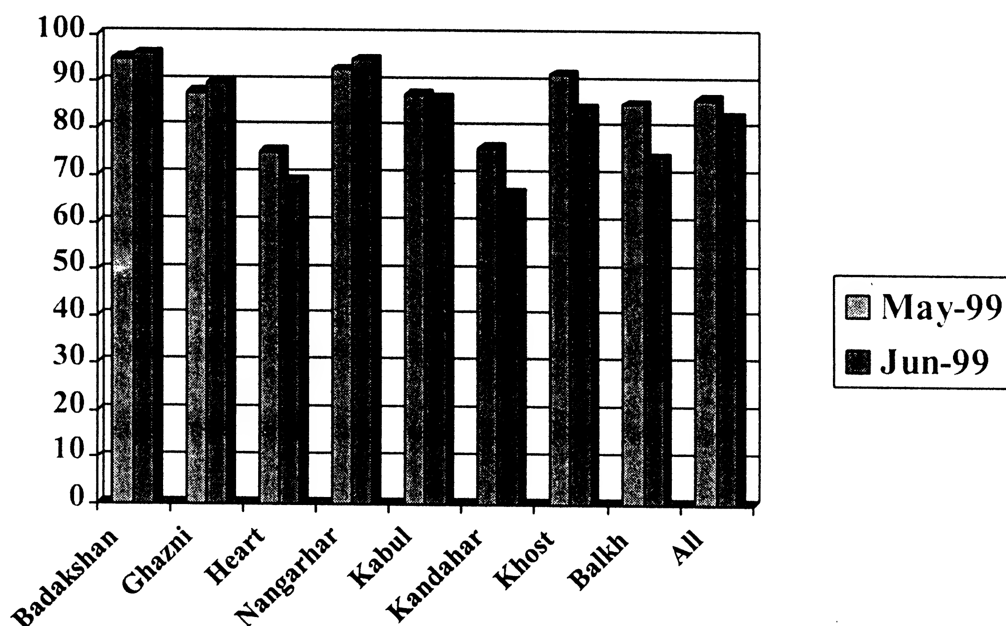
Coverage of NIDs 1999
Rapid Assessment March **2000**

Cluster Survey 1999

- 8 Provinces - Badakshan, Kabul, Herat, Ghazni, Khost, Nanganhar, Kandahar, Balkh
- WHO 30 cluster survey methodology
- Random selection of districts
- 3 focus areas: NIDs, routine EPI, TT
- Analysis completed in EPI INFO

Overall reported coverage from cluster survey 1999
May 1999 = 86.5%
June 1999 = 82.9%

Distribution of NIDs coverage among children (<5 years) by area



Reasons for not vaccinated during May or June 1999
Top 3 reasons:

- Service not available **(28%)**
- Not informed **(21.4%)**
- Family too busy **(13%)**

Channels of information for NIDs 1999
Top 4 channels:

- Loudspeaker **(40%)**
- Mullah **(38%)**
- Health workers **(21%)**
- Community leaders **(10%)**

Rapid Assessment, March 2000

- Increase the number of female vaccinators to enhance access an increased coverage
- Update national EPI policy/strategy to include long-term communication plan
- Broaden partnership to include key health and non-health agencies in Afghanistan
- Create technical capacity at the district level to coordinate and manage the programme
- All health workers must contribute to EPI delivery

Challenges/Opportunities in Afghanistan:

1. Inspite of the huge infrastructure in place, routine EPI coverage is still very low.
2. The findings and recommendations from 1998 review and 2000 rapid assessment need to be vigorously implemented.
3. The overall EPI strategy/policy for Afghanistan should be revised and documented
4. Experience gained in NIDs planning and implementation should be replicated in routine EPI.
5. All health workers should be mandated to perform EPI activity in their respective facilities
6. Additional partners/stakeholders are needed to support EPI implementation.
7. NID coordinators to continue as district EPI Co-ordinator to strengthen supervision.
8. NID social mobilizers to continue to support routine EPI.
9. EPI should be integrated in the existing health structure at all levels.
10. Innovative strategy should be shared among the regions.
11. Improve quality of NIDs to reach the unreached.
12. Expand surveillance and involve community in polio case detection and reporting.

Experience from other countries
<u>Silvia Luciani's Presentation</u>

Lessons learned from the

CASE STUDIES

Focus:

❶ Background
❷ Innovations and strengths from the cases studied
❸ Common concerns and suggestions

	bottle necks/obstacles
- Not reaching the objectives of wk/shop	- Time management & use experiences
- Sharing experiences	- Active group work
- Female involvement	- Specific attention on how to reach females in particular
- Reasons why polio eradication is a priority	- Time in programme for discussion on reasons why
- How to reach communities	- Practical strategy and action plan
- Would the knowledge gained from the wk/shop be applicable for other sectors	- Develop broad communication strategy applicable to other sectors

5. VIPP Rules when VIPP cards are used

- Write clearly
- One idea per card
- No capital letters
- No more than 3 lines per card
- Key words only
- Use a big marker
- Different colours for different categories

6. Feedback Committees and issues to be covered:

i. Day-1 (Monday, 15^{th}) Dr Waheed, Dr Amiri, Ahmad Masoud
ii. Day-2 (Tuesday, 16^{th}) Mr Hemati, Ms Riffat Sardar, Dr Dost
iii. Day-3 (Wednesday, 17^{th}) Dr Imran, Dr Wardak, Dr Karim
iv. Day-4 (Thursday, 18^{th}) Dr Katawazi, Dr Iqbal, Dr Rahmatullah

Issues to be covered by Feedback Committees:

- Objectives of workshop
- Common understanding
- Active participation
- Logistics
- Time management
- Include any other issues mentioned by participants

7. Problem analysis – Low routine EPI coverage:

a. Background information on the Polio Eradication Strategy for Afghanistan:

Current Status of NIDs:

- Afghanistan is now one of the 14 most important polio reservoir countries in conflict.
- MICs/NIDs have been conducted since 1995 during low transmission seasons (Oct-March) with supplementary OPV coverage ranging from 80% (in 1998) and 95% (in Oct 1999) of children under-5 years.
- Sub-NIDs in border districts with Iran and Pakistan during the same period.
- Four rounds of NIDs conducted in 1999 alone (May/June/Oct/Nov)
- Four more rounds planned in 2000 (May/Jun/Oct/ Nov)
- 4 or 5 rounds planned for 2001 in addition to mopping up and sub-NIDs.

Case Studies:

Why:

- ☛ To collect and document and exchange lessons learned in communication for polio eradication and EPI
- ☛ To integrate lessons learned within the communication strategies to accelerate the achievement of 2000 polio eradication goal
- ☛ To distill best practices that can be applied to other initiatives

Where:

- ☛ Mozambique, Mali, Zambia, Democratic Republic of Congo, Nigeria

Who:

- ☛ Teams from MOH, UNICEF, WHO, USAID/BASICS-CHANGE

How:

- ☛ Document review, observations, interviews (health professionals, media, influential leaders, care takers...)
- ☛ Capital, visit of two provinces, two districts in each one

Mozambique

Strengths and innovations

- Make successful NIDs a non-partisan, essential, national objective
  - ☛ All civic groups & political parties fully supported NIDs as integral part of the country development
  - ☛ *"If Polio comes, it won't pay attention to whether the child is a RENAMO or FRELIMO child - it will affect any child"*

- Strong support from local leaders
  - ☛ Active participation of religious leaders, traditional chiefs and healers in mobilizing the polpulation

- Strong partnership with broadcast and print media
  - ☛ Journalists trained in EPI for improved technical accuracy & greater sensitivity to health issues
  - ☛ Best Health Journalist Prize
  - ☛ Journalists covered all aspects of NIDs (planning, preparations, NIDs and post NIDs)
  - ☛ Journalist played role in advocacy through key articles in news papers

Mali

Strengths and innovations

- Intersectoral co-ordination committee, led by a very respected and influential leader: General A. Toumani Toure (ex-president of Mali and president of the *Fondation pour l'Enfance*)

- Strong network of rural radios: 95 rural radios addressing everyday local issues

- Social mobilisation by children through their active participation into a radio programme (design and production)
  - parents mobilisation
  - future parents sensitization to health issues

- Some effective community involvement
  - Training of traditional chiefs of nomadic clans in Kidal (Northern Mali)
  - Creative emergency effort in the Mopti region: canoes to transport vaccination teams and equipment

Zambia

Strengths and innovations

- Community ownership: Neighborhood Health Committees played a major role in development of each district plan
- Targeted strategies to hard to convince/reach groups
  - Apostolic church: vaccination teams stayed later and moved to location of seminar
  - Jehovah's Witness: additional sensitization meetings and door to door promotion
  - Chinese commercial farm: pressure to the manager

- Effective ways to combat rumors at the community level
  - Written guidelines
  - One spokesperson for all EPI information
  - Intensified health education by outreach workers and door to door immunisation

DR Congo

Strengths and innovations

- "Days of Tranquillity" negotiated by UN Secretary General: authorities mobilised even in areas held by rebels
  - Army: ceased fire, took barriers off, helped in logistics, protected vaccinator teams

- Proactive attitude of multilateral and bilateral representants. During NIDs launch:
  - Ms. C. Bellamy in Lumbubashi
  - US Ambassador in Kikwit

- ➢ Participation of accredited ambassadors and other UN agencies representants (Kinshasa and other provinces)

☛ Proactive attitude of belligerents
- ➢ Mai-Mai facilitated vaccine transportation (Kivu)
- ➢ *Forces Armees Congolaises* transported vaccine to Oriental Kasai

☛ Large media coverage
- ➢ International media (RFI, VOA, CFI, BBC, Afrique No 1) more impact at local level
- ➢ With participation of national celebrities

Nigeria

Strengths and innovations

☛ Integrated communication plan: NIDs, Routine, Surveillance

- ➢ Clear objectives
- ➢ Key behavioral problems, identification of target groups, related communication strategies, activities, relevant channels and messages
- ➢ Indicators for social mobilisation, programme communication and advocacy at National, State, LGA level

☛ The Challenge CUP Initiative: a strong advocacy strategy:

- ➢ to get Nigerian men to appreciate their responsibility as Caring Understanding Partners who would love to see their children polio-free
- ➢ six-match competition among three leading and popular football clubs
- ➢ radio and television spots, posters, stickers football stickers, t-shirts
- ➢ three role models

Common Concerns:

❶ Lack of reliable data.
Difficulty to measure real success of NIDs and routine coverage *(Mozambique, Mali)*

- ✓ Adjust census figures to realistic levels on the provincial and/or district level for estimating coverage
- ✓ National and/or provincial surveys
- ✓ Series of internal comparisons of the number of various antigens

❷ Insufficient basic health education/ information in addition to social mobilisation;
- ☛ People have been mobilised but not educated *(Mozambique, Mali, Nigeria)*

- ✓ Face to face communication activities as well as mass media
- ✓ Involvement of non-health professionals to provide health education (through church, media, schools etc)
- ✓ Prototype of EPI health education material to be adapted
- ✓ Basic of health education in schools curriculum (school children as mobilisers and educators)

❸ Scarce communication activities for routine immunization and surveillance

- ✓ Share Nigerian integrated communication plan
- ✓ Further dissemination of the Communication Handbook and follow-up on integrated communication plan implementation

❹ Lack of research data on Knowledge Attitude and Practice of stakeholders; insufficient utilization of findings when data exist

- ✓ Well-designed in-depth studies to answer key questions
- ✓ Clearly presented and effectively brought up into program and communication planning findings
- ✓ Promotion of previous data findings utilisation: Creation of an easy to access KAP studies regional data base?

❺ Need to make communication activities more strategic and therefore more cost-effective

- ☛ Specific communication objectives
- ☛ Emphasis on gender-specific strategies
- ☛ Process and impact indicators

❻ Lack of active involvement of the various stakeholders in planning and implementing all three interventions *(EPI/NIDs/surveillance)* for polio eradication

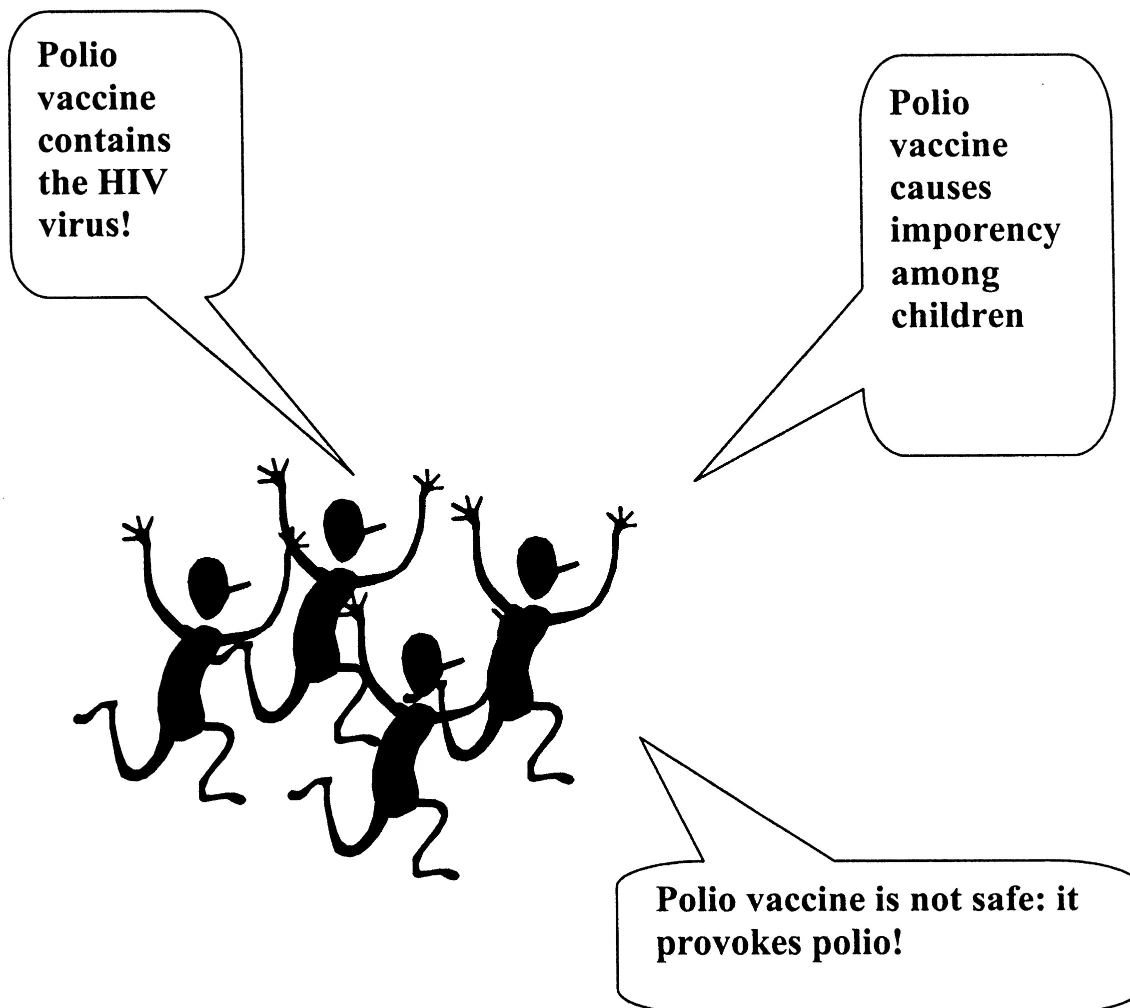
- ✓ Involve communities by soliciting their ACTIVE and EARLY participation in the planning phase of NIDs and routine EPI
  - ☛ a potential that remains largely untapped

❼ Need to identify ways for taking advantage of momentum created by NIDs to improve routine EPI

- ✓ inter-sectoral committees at various levels to promote immunisation and other child other child health services

- ✓ devise one or two simple indicators that can also be publically monitored
  - ☛ friendly competition, stimulation of problem analysis and action, periodic and clear feedback

❽ Identify effective ways to address rumors against polio immunization



Key Communication Definitions

KEY TERMS:

Below are the key communication terms to be used in UNICEF documents and planning processes:

Communication for development is a researched and planned process which is crucial for social transformation, operating through three main strategies: *advocacy* to raise resources and political and social leadership commitment for development goals; *social mobilisation* for wider participation and ownership; and *programme communication* for changes in knowledge, attitudes and practices of specific participants in programmes. When combined with strategies for the development of appropriate *skills* and *capacities*, and the provision of an *enabling environment*, *communication* plays a central role in positive behaviour development, behaviour change and the empowerment of individuals and groups.

Advocacy is a continuous and adaptive process of gathering, organising and formulating information into argument, to be communicated through various interpersonal and media channels, with a view to raising resources or gaining political and social leadership acceptance and commitment for a development programme, thereby preparing a society for its acceptance.

Social mobilisation is a process of bringing together all feasible and practical inter-sectoral social partners and allies to determine felt-need and raise awareness of, and demand for, a particular development objective. It involves enlisting the participation of such actors, including institutions, groups, networks and communities, in identifying, raising, and managing human and material resources, thereby increasing and strengthening self-reliance and sustainability of achievements.

Programme communication is a research-based, consultative process of addressing knowledge, attitudes and practices through identifying, analyzing and segmenting audiences and participants in programmes and by providing them with relevant information and motivation through well-defined strategies, using an appropriate mix of interpersonal, group and mass-media channels, including participatory methods.

COUNTRY PLAN OF ACTION
FOR
NATIONAL IMMUNISATION DAYS (NIDs)

AFGHANISTAN
Spring 2000

January 2000

MOPH
WHO
UNICEF

1. Introduction

Major gains have been made in the past few months towards the global commitment to eradicate polio by the end of the year 2000. The count down to reach this deadline is ongoing with full force. In 1988, virus circulated widely on all continents except Australia. By 1998, the Americas were polio-free; transmission has been interrupted in the Western Pacific Region of WHO, including China, and in the European Region, except for a small focus in Southeast Turkey. Currently, only three major foci of transmission remain South Asia (Afghanistan, Pakistan, India), West Africa (mainly Nigeria) and Central Africa (mainly Democratic Republic of Congo).

The eradication of polio has been achieved through using the following strategies:

- High routine immunization coverage;
- National Immunization Days (NIDs)
- Surveillance and investigation of acute flaccid paralysis (AFP) cases; and
- Mopping-up immunization in areas or among populations where poliovirus transmission persists.

Afghanistan remains in the complex emergency since 1979. This has been the major cause for the destruction and complete breakdown of infrastructure in every sector including the health sector. Although gains have been made in establishing a functional Regional level management structure, Afghanistan EPI is still far from attaining the desirable coverage and consistency of routine service delivery.

Moreover, polio still remains an endemic disease in Afghanistan, with a potential to transmit wild poliovirus to the neighboring countries. It is becoming more obvious that failure to eradicate polio in Afghanistan will jeopardize progress of the polio eradication so far achieved in these countries as well as in the entire world. The urgent need for eradication of polio in Afghanistan therefore remains one of the highest priorities for the global polio eradication initiative.

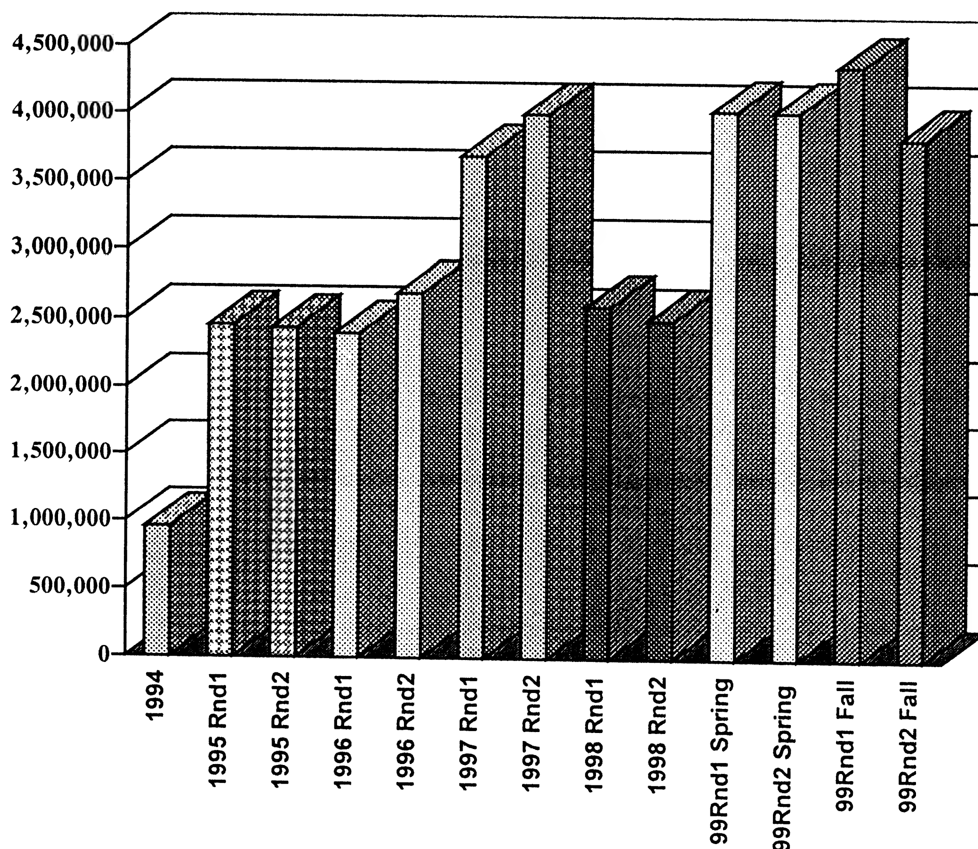
Afghanistan has already maximized its efforts to reach the eradication goal by the end-2000 or as close to it as possible. The country has been coordinating its eradication efforts with the Middle Eastern, Caucasian and Central Asian Countries (MECACAR) in the north and with both Pakistan and Iran. High coverage was achieved during the NIDs conducted in conjunction with Pakistan and Iran, who implemented SNIDs in the districts bordering Afghanistan. Synchronized schedule for NIDs and SNIDs has been developed along with Pakistan to ensure added epidemiological advantage.

To build further on the good experience gained during several rounds of NIDs since 1994 and the micro planning exercise conducted in August 1999, efforts are underway to provide support to the WHO/UNICEF sub-offices, MoPH and other partners to further refine the district micro plans. The objective during the forthcoming NIDs is to reach all under five children in every district of Afghanistan. The numbers of districts reached during the first round of fall NIDs were 325 out of a total 330. This was a further improvement on 320 districts reached during the first round of 1999. With strengthening of WHO/UNICEF staff in the field, it is expected that thorough district level micro planning exercise would be undertaken in the coming months to ensure an optimal implementation of the next NIDs. We also expect that in order to successfully implement these campaigns, UN will make more concerted efforts to in year 2000 to negotiate days of peace and tranquility between the warring factions during the NIDs.

Plans are already under implementation to refresh the knowledge of all vaccinators and district coordinators in EPI and polio eradication. Training of the above category of workers is going on simultaneously in various regions of the country. In addition, a large number of health workers and

volunteers have been trained over the years to administer OPV and Vitamin A capsules to the target population. The campaigns have also facilitated the expansion of routine EPI services to more districts and strengthened the coordination among different partners, as well as strengthened the capacity of the provincial and district staff in micro planning and implementation of mass campaigns. NIDs continue to provide the only chance, where district level staff will be participating in the planning process at the grass-root level. The district information collected in the course of preparing the micro plans would be extremely useful in understanding the diverse situations at the district level, and would also help make district level planning possible for other programmes.

Afghanistan NIDs coverage 1994 to 1999



A sentinel based AFP surveillance system was established in September 1997. So far a total of 274 cases of AFP have been detected, out of which 126 were confirmed as polio. Reporting of measles and neo-natal tetanus has been successfully integrated with the AFP surveillance. Currently 65 sentinel sites are also reporting measles and neonatal tetanus cases as well. So far in 1999, a total of 2,178 cases of measles have been reported from 21 provinces. Moreover, 49 cases of neo-natal tetanus have also been reported from five provinces. An ambitious plan for expansion of AFP surveillance and reporting of measles as well as neonatal tetanus is being developed for the next biennium.

This document will detail the objective, strategy, implementation process, monitoring mechanism and other necessary planning and operational arrangements for the implementation of year 2000 NIDs. Based on this national plan of action, each district will prepare a micro plan for implementation of NIDs to achieve the desired objectives as described in the subsequent paragraph.

2. Objectives of the NIDs:

The long-term goals of the NIDs are:

- Interruption of the transmission of wild poliovirus, and thus polio eradication in Afghanistan, by the end of year 2000 and;
- Prevention of Vitamin A deficiency among children and also to reduce mortality and morbidity arising from measles and ARI.

The specific objectives are:

- To reach 100% of children aged zero to 59 months with two supplementary doses of polio vaccine in all districts of Afghanistan; and
- To cover all children between the age 12-59 months with vitamin A supplementation during the second round of the campaign.

3. Beneficiaries of NIDs:

The total population in the 31 provinces and 330 districts of Afghanistan is estimated to be 21.9 million for 1999. The primary beneficiaries for NIDs are approximately 4.49 million children under 5 years of age.

Children aged 12-59 months are recommended one full dose of vitamin A supplementation every six months especially if they are potentially in danger of vitamin-A deficiency. Therefore, vitamin A supplementation during NIDs is an opportunity. About 3.6 million children are expected to benefit from vitamin A supplementation to be carried out along with the OPV campaign for children.

4. NIDs duration and dates

Considering the low routine coverage and the proximity of the target date, it has been agreed among the partners to conduct two yearly NIDs of two rounds each during the year 2000. The second NIDs of 2000 will follow the two rounds of NIDs implemented earlier in spring of 2000. In Afghanistan, it is

Status of routine EPI (UNICEF):
- EPI services established in 80% of the districts
- Coverage of DPT3 in children under 1 was 36% at end of 1999 while measles coverage was 41%
- TT2 coverage for women was 18%
- Need to correct the missed opportunity and defaulting rate in completing the required doses.

Status of AFP Surveillance in Afghanistan (source: WHO data April 2000):
- AFP surveillance established since September 1997
- 86 sentinel sites in 44 districts out of 330
- The system has so far detected 520 AFP cases of which 237 were confirmed polio (Sept 1997 - April 2000)
- Plan to expand to 200 sites in 2001 covering 130 districts
- Need to further improve the performance indicators, provide more supplies and equipment, and establish community based referral points.

Reasons for not vaccinated during May or June 1999:
Top 3 reasons:
- Service not available **(28%)**
- Not informed **(21.4%)**
- Family too busy **(13%)**

Channels of information for NIDs 1999:
Top 4 channels:
- Loudspeaker **(40%)**
- Mullah **(38%)**
- Health workers **(21%)**
- Community leaders **(10%)**

Recommendations of the Rapid Assessment, March 2000:
- Increase the number of female vaccinators to enhance access and increased coverage
- Update national EPI policy/strategy to include long-term communication plan
- Broaden partnership to include key health and non-health agencies in Afghanistan
- Create technical capacity at the district level to coordinate and manage the programme
- All health workers must contribute to EPI delivery

b. Problem analysis by workshop participants:

i. Non-Behavioural Causes:

a. Political	- political instability - institutional disruption
b. Human resources	- lack of trained human resources - lack of female vaccinators - lack of communication skills/poor training

difficult to cover the entire target population in one day due to difficult terrain, logistic difficulties and great differences in population density. Therefore, each round of the campaign will be of three days duration.

5. Implementation strategy and major activities

The strategy for the NIDs have been developed using experiences from previous campaigns (of multi-antigen campaigns and NIDs), recommendations of EPI review 1998 and the decisions made during the micro planning workshop in Peshawar (16-18 August 1999). Activities planned for spring 2000 NIDs is as follow:

5.1 Planning and coordination

The central level Technical Coordination Committee (TCC) comprising representatives from Ministry of Public Health (MoPH), UNICEF, WHO and Non Governmental Organisations (NGO's) are responsible for providing technical, logistical and operational support to the regional authorities. Similarly, regional and provincial EPI coordination committees will be responsible for facilitating the process of development of a micro plan for each district. This would include estimation of resource requirements, training of staff, mobilization of the community, mapping of the district and delegating specific geographic areas of responsibility to the NIDs implementation staff at the sub-district level. Standardised formats developed after the micro-planning workshop of August 1999 will be used in the field to develop NIDs district micro plans.

The Regional EPI Management Teams (REMT) and Provincial EPI Management Teams (PEMT), where available, will review the district plans and submit it to TCC. Based on these plans, TCC will allocate resources and decide on technical assistance needed to provinces.

5.2 Geographic coverage

NIDs will be implemented in all the 330 districts of Afghanistan. House-to-house immunisation strategy will be implemented in six major urban areas selected on the basis of poor routine, low NID coverage and wild poliovirus activity. The urban areas, which would be implementing the house-to house, will be:

- Kabul
- Herat
- Kandahar
- Jalalabad
- Mazar
- Kunduz

5.3 Supplementary immunisation with OPV

In each round, one dose of polio vaccine (two drops) will be orally administered to all children under five years of age irrespective of their OPV vaccination history.

5.4 Provision of vitamin A during NIDs

In view of vitamin A deficiency being a major public health problem in Afghanistan, efforts are being made to reach children 6 - 11 months age group with vitamin A supplementation during the

routine immunisation programme. Children more than 12 months old are therefore being covered during periodic campaigns. NIDs offers an excellent opportunity to administer one dose of vitamin A (200,000 IU) to children aged 12-59 months, which will be provided during the second round of the campaign.

5.5 Service delivery posts

Immunisation of children will be carried out through OPV posts established in public places such as mosques, schools, madrasas, health posts, or at private houses where the target group will have easy access to immunisation. Taking into consideration the geography, communication and population density of the area, each district will be mapped and divided into clusters. The basis for demarcating a cluster would be the area, which can be effectively supervised by one supervisor. A map of each cluster would be drawn. Responsibility for specific geographic areas will be given to various vaccinator teams. Their routes and itinerary would be chalked out and monitored accordingly.

OPV posts will be chosen in consultation with the community elders. The team would move from the post to another one in rural areas to ensure that all children under five in the area of their responsibility are covered. In the urban areas not implementing house-to-house strategy, the immunisation team will review their performance against the target by mid-day and may decide to move systematically within the operation area for the remaining part of the day to trace and immunize children who did not visit the immunisation post.

OPV posts will be chosen as follows:

- OPV and vitamin A will be provided daily during the NIDs from all fixed EPI centres, hospitals, Basic Health Centres, MCH clinics and rehabilitation centres;
- OPV posts will be mainly established in the community, for example at mosques, schools or any other centres of the village or city. Efforts will be made to choose OPV posts at sites that are known to the public and easily accessible. Especially in the rural areas, the immunisation posts will be selected with the help of the community elders. The immunisation team may also need to change sites each day according to the geography and the estimated number of children in their sub-cluster.
- To cover the children, who may be travelling, OPV posts will be established at all bus stations, and at the border crossings.

Supervisors assisted by volunteers and social mobilizers will identify the appropriate location for OPV posts in consultation with the community elders and also inform them about the dates of NIDs. Community elders will also be requested specifically to mobilise the parents to bring their children for immunisation. Supervisors will prepare a plan for each team to move from post to post in order to immunise all eligible children during the three days of the campaign.

Guidelines for planning and training have been developed, see **Annex A**.

5.6 Manpower

The Regional Planning Team will assess requirements of the personnel. As has been the practice, one of the directors of the district health centres will be enrolled as district NID co-ordinator.

The district NIDs coordinator will prepare the district plan for the NIDs based on the new standardised micro plan format. The district co-ordinators will then ensure that the cluster supervisors, vaccinators, health workers and local administration (waloswal) are well familiar with the plan and the required district maps and cluster maps are available.

Cluster supervisors will be responsible for the coverage of OPV in their cluster. Social mobilizers will be recruited to support the social mobilization in the district.

In each OPV post one immunisation team, consisting of two volunteers, will be deployed to organise sites, control crowds, maintain records and administer polio vaccine and vitamin-A. Immunisation team members and social mobilizers will be selected strictly on the selection criteria outlined in the guidelines. The number of teams needed per district and cluster will be determined during the district level micro-planning exercise considering the size of the target population and geographic factors. This will have to be confirmed by the provincial co-ordination team after proper review.

5.7 Training

A national level training team, comprising representatives from, MoPH, WHO, UNICEF and key NGOs will be formed to take appropriate actions for effective training for the different categories of staff.

REMT and PEMT will be responsible for training. All the district NIDs coordinators, the supervisors, the immunization teams and the social mobilizers will receive training on how to give OPV and vitamin A, vaccine handling, safe waste disposal, recording and inter-personal communication skills. Provincial trainers will train the required number of supervisors. In turn, supervisors will train volunteers at district level.

5.8 Supply, logistic and transport

Cross-border delivery of vaccines and other supplies either overland transport or by air will be made according to the NIDs timetable (see section 10). Supplies to the Northeastern and Northern regions will be dispatched by air (UN plane). All available means of transport (four-wheel vehicles and motorcycles) will be deployed for dispatch of supplies and supervision purposes. UN agencies, NGOs and the community will be approached to provide assistance in this regard.

It is estimated that a little around 12 million doses of OPV (20 dose vials) and almost 4 million capsules of vitamin A (bottles of 500) will be required for the NIDs in spring 2000. A total of 15,000 information and advocacy kits, one million leaflets, 25,000 volunteers guidelines will be locally produced. Arrangements will be made to deliver supplies at least two weeks in advance to the regions and one week to the provinces.

Vaccines will be carried to the sites in vaccine carriers with frozen ice packs inside. The district coordinator will arrange delivery of vaccines and vitamin-A to the team based on the target population per site. All used, partially used and unused vials of vaccine will be returned to the supervisor after completion of each day's session. Unopened vials will be returned to the main cold chain unit, after checking the potency of the vaccine through the VVM indicator.

In each region, the REMT will calculate the amount of OPV, vitamin-A, and communication materials required on the basis of the district micro plans. A detailed plan will be developed to dispatch the supplies well in time to the regions. REMT and PEMT will make arrangement to produce sufficient number of ice packs prior to the campaign.

5.9 Social mobilisation

A national level social mobilisation team will be established to develop a comprehensive plan. This team will also develop communication material for the NIDs. A one-day meeting would be organised for MoPH and NGOs in Peshawar to present the plan and seek support of all partners.

The emphasis of the social mobilisation campaign would be to ensure larger community involvement, especially in the NIDs and awareness about the importance of routine immunisation. Local leaders will be fully utilised in raising awareness for immunisation in the respective communities. All local and international channels of mass media will also be utilised to disseminate the NIDs messages to the people.

Imams, teachers and village elders will be recruited to serve as social mobilizers. It is estimated that 1328 social mobilizers will take part in the community mobilization. To ensure support from the cross-sectoral groups in community mobilisation, advocacy workshops will be organised at the province level. Special efforts would be made to mobilise support from all partners in the field. Education sector will be specially targeted to play an important role in the social mobilisation of communities.

Social mobilizers will assist the supervisors in identifying the place for OPV posts in consultation with the village elders. They would also ensure that all community leaders including, village elders, imams, teachers and parents are aware of the location and dates of NIDs. They will also be responsible to distribute information material as needed.

The Regional Coordination Team will establish a close working relationship with Radio Shariat to announce benefits of polio immunization, vitamin A supplementation, vaccination schedule, possible place for establishment of immunization sites, and importance of completion of routine immunisation within the first one year of life. Imams will be urged to start announcing the date and place of OPV sites over the microphones of the mosques at least 5 days in advance and reinforce messages during the Friday congregation. They will also be urged to make the announcements many times a day during the three days of implementation. An information kit containing relevant communication messages will be developed and distributed to potential mobilisation allies. Megaphone will be used extensively to propagate messages to the community and flags and banners will be used to mark the NID posts.

All national and international channels of mass media will be utilised to disseminate the NIDs messages to the people. BBC, VOA, Radio Shariat (Radio Kabul), local radio stations will be utilised to inform the people on the NIDs.

5.10 Advocacy for cease-fire during NIDs

In areas of conflict, efforts will be made to secure days of peace and tranquillity by negotiating with all warring factions. High level UN officials will carry out negotiations with the assistance from MoPH and other authorities. Local WHO/UNICEF offices and

MoPH staff will be encouraged to make local level efforts to negotiate peace and crossing of supplies and NIDs staff across frontlines.

6. Monitoring of NIDs implementation

TCC and regional coordination committees will closely monitor implementation of planned activities to ensure achievement of objectives and strategies. The REMT and PEMT will have the primary responsibility to supervise activities in the field with the support of directors of health centres. Nine national EPI officers plus four EPI trainers from WHO and recently recruited five EPI national officers from UNICEF along with other national and international staff from both the organisation. NGOs will be encouraged to provide members of their staff based in Afghanistan to join the team of supervisors during the two rounds of NIDs. Specific checklists would be provided, collected and analysed to determine the extent and effectiveness of the campaign.

6.1 Recording of doses

Administration of OPV and Vitamin A will be recorded in the tally sheet. Each team will be provided with sufficient number of tally sheets to properly record the number of children immunised in each session. This record will then be handed over to the supervisors for compilation. The district NIDs coordinator will compile the district report and submit it to the PEMT. The provincial reports will after thorough review be sent to the REMTs and then to TCC for consolidation in the national report.

6.2 Supervision of activities

Activities in each district will be supervised by the district NIDs coordinator who will be responsible for delivering vaccines to the teams, facilitate movement of immunization teams, collect daily performance reports and conduct overall supervision of the campaign implementation within the districts. A supervisory checklist will be developed to enable the coordinators in monitoring the work of the teams effectively. The cluster supervisors, who will supervise and monitor the planning and implementation of NIDs in their respective clusters, will assist district co-ordinators.

6.3 Indicators for NIDs

For the purpose of overall monitoring of NIDs the following indicators will be used and recorded:

1) Total number of vials of OPV dispatched per round of NIDs;
2) Total number of children less than 5 years of age receiving OPV per round of NIDs;
3) Total number of doses of vitamin A dispatched; and
4) Total number of children between 12-59 months receiving vitamin A.

7. Partners

Implementation of NIDs is the prime responsibility of the Ministry of Public Health. However, for the purpose of effective implementation of the programme, active partnership with public and private sector agencies will be sought. TCC will play an essential role in providing support on policy and technical issues at central and regional levels. NGO's working in the health sector

will collaborate in community mobilization, facilitate delivery of supplies, service delivery and monitoring.

WHO and UNICEF will play the leading role at national level for mobilization of resources and the planning process. UNICEF will be specifically responsible for providing technical support and operational costs to five administrative regions, and mobilize funds for OPV, vitamin A, equipment and supplies. WHO will be responsible for training of all categories of staff in all regions and provide operation costs for three administrative regions. The five UNICEF sub-offices and nine sub-offices of WHO located in Afghanistan will have primary responsibility for coordinating activities.

Other UN agencies (UNCDAP, UNHCR) that have field level structures are expected to support regional and provincial coordination committees in planning and monitoring. UNOCHA will play a coordinating role in mobilizing all UN agencies to support the event and provide logistic support to facilitate movement of supplies and service providers.

NGO's such as IbnSina; Swedish Committee for Afghanistan, KJRC and Norwegian Afghanistan Committee will provide support in the overall planning, implementation and mobilisation. Other Health sector NGOs working in close collaboration with TCC and regional authorities will assign staff for monitoring of activities, provision of service delivery, community mobilisation and logistic management. NGO coordinating bodies such as ACBAR, SWABAC, ICC and ANCB and federation societies (ICRC, IFRC) will also be approached to provide necessary support to the NIDs.

8. Budget

UNICEF and WHO have already initiated mobilising resources from potential donors. Funds for procurement of vaccines, vitamin A, communication materials and cold chain equipment will be mobilised by UNICEF. Cash component to cover operations, transportation and social mobilisation costs will be jointly mobilised by WHO and UNICEF. UNICEF will channel operational funds to the regions of Central, Southern, Eastern, Western and northern regions, while WHO will channel funds for North-eastern, South-eastern and West Central regions. The breakdown of resource requirements, including OPV, vitamin A, operation costs, training, and social mobilisation are shown below:

Summary cost of NIDs in Spring 2000

Items	Number	Cost (US$)	UNICEF	WHO	Formula for calculations
Total population of Afghanistan in 2000 (estimated)	22,250,097				Plus 2.4% growth c previous year's populatior
Target age group:	4,450,019				20% of above
OPV (vials, including freight)	578,503	960,314	960,314		Target pop. X 2 dose (rounds) X 1.3 wastag factor / 20 doses per vial
Vitamin A (capsules)	4,005,017	144,181	144,181		Only for children of one t 5 years
Cold chain equipment		200,000	200,000		
Number of teams	13,865		9,328	4,537	Based on the number teams of Oct. - Nov. NIDs
Number of staff					
- Supervisors (including district supervisors)	2,311		1,555	756	One supervisors for teams
- Volunteers	27,730		18,656	9,074	Two volunteers for eac team
- Coordinators (provincial)	31		23	8	One for each province
Operation cost					
- Per diem of supervisors		69,325	46,640	22,685	US$ 3 per person X 5 day X 2 rounds
- Per diem of volunteers		415,950	279,840	136,110	US$ 2.5 per person X days X 2 round
- Provincial NIDs coordinators		31,000	23,000	8,000	US$ 200 per person pe month X 5 months
- Transportation for supervision	662	198600	139200	59400	As before: 2 cars X 5 day X US$ 30 per day X rounds
- Fuel for transportation (car)	331	49650	34800	14850	1 car X 5 days X US$ 1 (only fuel) X 2 rounds
- Transportation of supplies to the regions and provinces		31000	23000	8000	US$ 1000 per province
Training cost					
- Training of supervisors	2,311	30,041		30,041	4 days training (includir travel time) X US$ 4 (nc resident) + US$ 1 pe person for facilitation ar stationery
- training of volunteers	27,730	138,650		138,650	US$ 2 per day only or day each round + US$ fo facilitation and stationery

- Developing and printing of training guidelines	30,041	15,020		15,020	US$ 0.5 per copy
Social mobilization:					
- social mobilization materials		49,800	49,800		US$ 150 per district
- Advocacy meetings		16,800	16,800		Based on Oct. Nov. 9 NIDs
Advocacy Meeting for Partners				12,000	Two one-day meeting with 60 participants
Evaluation		40,000	20,000	20,000	Do
Accessories		10,000	10,000		Estimate
Staff support					
Sub-total NIDs		2,400,331	1,947,575	464,756	
Mopping up in selected districts (25% of the total budget)		564,038	450,849	116,189	
Total NIDs+Mop-up		**2,964,369**	**2,398,423**	**580,945**	

2000 GUIDELINES FOR PLANNING AND CONDUCTING NATIONAL IMMUNIZATION DAYS (NID'S) FOR POLIO ERADICATION AT DISTRICT LEVEL IN AFGHANISTAN

(PLEASE REFER TO HOUSE-TO-HOUSE GUIDELINES FOR THE MICROPLANNING EXERCISE OF THE CITIES OF KABUL, KANDAHAR, JALALABAD, HEART, MAZAR AND KUNDUZ)

1.0 INTRODUCTION

These guidelines have been developed for the supervisors and volunteers that will assist during the two rounds of NID's in Afghanistan in Spring 2000.

2.0 OBJECTIVES

- To conduct two rounds of NID's at least one month apart in line with the polio eradication initiative;
- To administer two doses of oral polio vaccine (OPV) to all boys and girls under five years of age regardless of their vaccination status; and
- To administer one dose of vitamin A during the second round of NID's to all boys and girls aged 12 to 59 months.

3.0 DATES AND DURATION OF NID'S

- First round: 1-3 May 2000.
- Second round: 3-5 June 2000.

4.0 ANTIGENS AND MICRO-NUTRIENTS TO BE ADMINISTERED

- OPV : Two drops given orally during both rounds
- Vitamin A capsules 200.000 IU:

  Children 12 to 59 months of age will receive one capsule.

  (Children less than 12 months of age will not receive vitamin A).

Vitamin A will only be administered during the second round of NID's

Vitamin A is available as a capsule containing 200.000 IU. For children 12 to 59 months of age open the capsule with a pair of scissors and squeeze all of the content into the child's mouth.

5.0 STRATEGY FOR THE NID's

5.1 Planning and coordination

REMT and PEMT should continue taking lead in forming regional and provincial NID's planning committees,who will be responsible for coordinating the activities prior to and during the NID's. District micro plans would also be finalized under the supervision of provincial NIDs planning committees. The committees will consist of persons from REMT, PEMT, WHO and UNICEF sub-offices and NGO's.

5.2 Selection of OPV sites

The district maps would be the basis for determining the number of clusters in a district. The basis would be the geographical area which could be supervised by one supervisor and covered by the selected number of teams in 3 days. **Each such cluster will have a map (sketch), which clearly shows the villages, geographical areas of responsibility for each team and determines the route and itenerary for each team.** The basis for dividing the district population into clusters would be:

- Number of teams that can be effectively supervised by one supervisor **(see below)**
- Number of villages/households which can be covered by a team in three days of NIDs **(see below)**
- No overlapping and no missed areas

The NID's district coordinator will coordinate and supervise the activities in his district. The NID's district coordinator and the supervisors will be responsible to assign staff to every cluster. Clusters would be classified as under:

- G-1→ easy Access by any means of transport——→ Objective is to reach every child below the age five years in the area of responsibility of the each designated vaccination team. **Ten teams to be supervised by one supervisor**
- G-2→ moderate Access by any means of transport ——→ Objective is to reach every child below the age five years in the area of responsibility of the each designated vaccination team. **6 teams to be supervised by one supervisor**
- G-3→ difficult Access by any means of transport ——→ Objective is to reach every child below the age five years in the area of responsibility of the each designated vaccination team. **3 teams to be supervised by one supervisor**

(above are indicative and suggested figures, the final decision should be guided by the micro plan) Moreover, a certain cluster may have a mix of both G1 and G2 or G2 and G3 or all three together. À mix of transport may then be selected for the plan.

c. Management/institutional - lack of AFP surveillance
- negative effect of NIDs on routine EPI/regular health services
- lack of supervision
- lack of monitoring
- no permanent communication committees
- no comprehensive communication plan of action
- lack of involvement of communities
- inadequate integration of EPI staff

d. Access to services
- poor access to remote areas
- insufficient number of fixed centres
- hard to reach population not targeted
- lack of fixed centres in cross border areas
- lack of transportation
- people's movement not addressed adequately
- location of vaccination centres not always appropriate

e. Information
- poor health information system
- no knowledge of the extent of problem

f. Materials
- lack of communication materials/channels
- untimely delivery of supplies

g. Finance
- inadequate resource allocation
- low payment to vaccinators

ii. Knowledge, Attitude and Behavioural Causes:

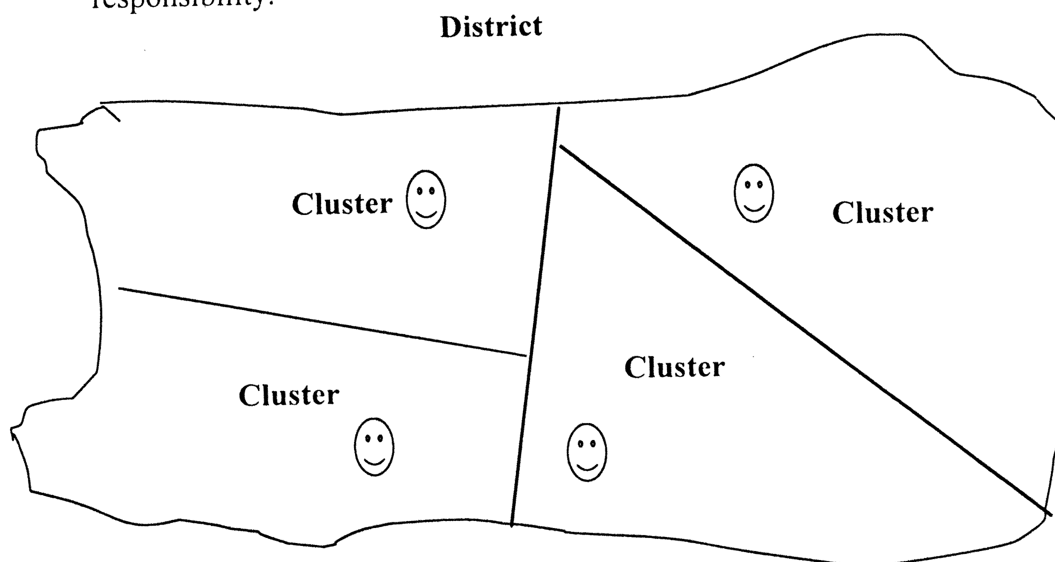
a. Medical professionals/service providers do not perceive NIDs as priority for Afghanistan. Non-optimal or weak coordination between MoPH, UN and NGOs
b. Low motivation of service providers leads to poor quality services
c. EPI/polio service providers do not communicate effectively with parents and care takers and therefore these do not bring the children for all required doses.
d. Communities do not participate in NIDs planning and AFP surveillance.

3. Problem Statement:

n Afghanistan immunisation coverage is low. Routine reporting of EPI coverage 1999:

Antigen	1997	1998	1999
BCG	66%	46%	48%
DPT/OPV-3	45%	37%	36%
Measles	57%	40%	41%
TT2 (CBA Women)	11%	11%	18%

Each team consists of two volunteers and will be responsible for covering all under-5 years of age children in the designated geographic area of their responsibility.



Supervisor (vaccinator teams as per the requirement)

The volunteer team will collaborate with the cluster supervisor to determine the location of the OPV posts (the posts should be selected in close consultation with the community leaders). OPV sites can be located in public places such as mosques, schools, madrassas, health posts bus-stations or a private house where all children can come for immunization.

5.3 Selection and responsibilities of district NID's coordinators, supervisors and volunteers

Each district will have one district NID's coordinator, one supervisor per cluster and a team of two volunteers per team. The number of teams per cluster may vary, depending on the target group and the geographical specifications of the cluster.

5.3.1 Selection and responsibilities of district NID's coordinator

Selection criteria:

- Should come from the district concerned;
- Head of MCH or head of Health Centre or one of the senior medical doctor from the health centre
- Able to train supervisors and volunteers.

Responsibilities of district NID's coordinator:

- Selection and training of supervisors and social mobilizers;

- Coordinate immunization activities in the district;
- Ensure that all children under five years of age are covered in the district;
- In collaboration with supervisors and social mobilizers inform community leaders (mullahs, teachers, village elders) about the NID's;
- Complete the micro plan for the district including, supplies, logistics, manpower and transport requirements **using district maps**;
- Make sure that adequate vaccines are available in the district to carry out the NIDs campaign;
- Make field supervisory visits by following various teams;
- Immediately after each NID's, deliver the completed district compilation sheet to the PEMT;
- Will tally the vaccine used and return the unused vaccine vials to the PEMT/REMT
- Will follow the checklist (planning/implementation)-**Annex-3**

5.3.2 Selection and responsibilities of supervisors

Selection criteria:

- Should come from the district concerned;
- Vaccinator, health worker or other literate responsible person (such as a teacher, veterinarian, water engineer etc.); and
- Able to train volunteers.

Responsibilities of supervisor:

- Selection and training of volunteers;
- Selection of OPV sites in collaboration with the volunteer and community in the cluster;
- Ensure that map (sketch) of the cluster concerned is available with each volunteer/team;
- Delgate each team a specific geographic area to cover each day;
- Prepare an itinerary **(see Annex 1-A and annex 1-B)** for each of the teams in his or her cluster during the three days of the NID's;
- Ensure that the teams have discussed and understood the route to reach all the villages in their area;
- Ensure that all children under five years of age are covered in the cluster;
- In collaboration with social mobilizers inform community leaders (mullahs, teachers, village elders) on the NID's;
- Calculate supplies needed for the designated cluster;
- Obtain supplies for the NID's and distribute supplies to the volunteer teams;

- Supervise all teams of two volunteers each in his/her cluster;
- Visit each volunteer team during each round of the NID's to supervise activities and complete checklist (**see Annex 2)** including checking the OPV vial monitor;
- Receive daily reports on number of children immunized from volunteer teams and compare reports with actual utilization of vaccines, enter reports in the district compilation sheet and deliver these sheets to the district coordinator;
- Obtain all used, partially used and unused vaccine vials by the end of the day from the team and return vials to the main EPI fixed centers for safe storage of unused vials and safe disposal of the used and partially used vials.

5.3.3 Selection and responsibilities of volunteers

Selection criteria:

- Resident (preferably resident of the cluster he/she has to cover) in area and hold respect in the community;
- Able to read and write; and
- Willing to work on full time basis during the campaign period.

Responsibilities of volunteer:

- Help draw the sketch of the cluster with the supervisor.
- Understand and note the specific geographic area of responsibility
- Understand and note the route and the itenerary for each day of the campaign
- Selection of immunization post in collaboration with the supervisor;
- Warmly greet the caretaker for bringing the child for immunization
- Give two drops of OPV to all children below five years of age and a capsule of vitamin A (only during the 2nd round) to the children between 1-5 years of age.
- Record OPV and vitamin A doses given in the tally sheet **(Annex 4)** and return it to the supervisor by the end of each day;
- During the first round of NID's, inform the caretakers of the dates for the second round of NID's and make sure that the caretaker understands that he or she should return with the child for the next round of NID's;
- During each round of NID's inform the caretakers of children less than one year of age that they should take the child to the health centre to receive the routine EPI vaccines;
- Maintain correct storage and handling of OPV during the NID's;

- Volunteer should return all used, partially used and unused vials to their supervisors at the end of each day.
- Ensure that all children under five years of age in their area of responsibilty are covered;
- Involve willing community members to find those children who were not brought to the immunization site to recive OPV during NIDs and give them OPV;

5.3.4 *Selection criteria:*

- Teachers, mullahs or persons well known in the community;
- Able to read and write; and
- Willing to work on full time basis during the campaign period as needed.

Responsibilities of social mobilizer:

- In collaboration with the supervisor, inform community leaders (mullahs, teachers, village elders) on the dates and significance of NID's;
- Inform caretakers on the dates of NIDs and venues for OPV sites;
- Assist the volunteers in crowd control;
- Ensuring that all children under five years of age in the area are covered;
- With the help of community volunteers trace and find children under-5 years of age who were not brought to the immunization site and convince parents/caretakers to bring the same children to receive OPV at the immunization site

5.4 Delivery and storage of OPV and vitamin A

6.4.1 Cold chain, storage and doses needed

OPV:

REMT will send OPV to district fixed centres and supervisors will distribute OPV to volunteer teams in vaccine carriers equipped with adequate number of frozen icepacks.

Based on previous year's experience a wastage multiplier factor of 1.2 will be adequate for OPV:

Example on how to calculate supply needs:

If it is estimated that there are 150 children less than 5 years of age in the area where a given team will go, one of the days during the campaign, the number of doses of OPV that needs to be taken should be calculated as follows:

150 doses x 1.2 = 180 doses

A total of 180 doses of OPV should be taken to the village. As OPV vials contain 20 doses, the volunteer team should take 9 vials.

Vitamin A

There is no need for cold chain storage and transportation of vitamin A.

The team should bring the same number of doses as the estimated number of children less than 5 years of age in the area where they will work.

Example on how to calculate supply needs:

A team of volunteers will go to an area where the estimated number of children less than 5 years is 112. Therefore, the team will bring 112 doses.

6.4.2 Equipment

Each team will need a pair of scissors **(during the second round only)**, one vaccine carrier with icepacks, one tally sheet per day (3 in total) and one pen.

6.4.3 Transportation

The PEMT in collaboration with the supervisor will provide appropriate and adequate means to transport OPV and vitamin A and to transport the supervisors to the vaccination sites. Furthermore, they should collect the district compilation sheet and deliver to PEMT.

It is suggested that:

- In G-1 areas, supervision should be done through motorbikes. One vehicle may be enough to drop vaccines for many clusters.
- In G-2 areas the supervisors can use motorbikes or a 4-wheel vehicle as needed
- In G-3 areas it may be mostly a mule, camel/other locally used mode of transport and rarely a 4-wheel drive vehicle.

It is strongly advised that:

- All efforts should be made to get a vehicle by a partner agency, an NGO and/or another UN agency etc.
- Moreover, community and local traders must be encouraged to provide any means of transport. If it is a vehicle, then the fuel can be charged to the NIDs operational budget for transport.

5.5 Training of supervisors and volunteers

5.5.1 Supervisors
Supervisors will participate in a two-day training course conducted by the district trainers. The course will take place at the **district** level. **(for budget/incentive rates see chart on page 10)**

5.5.2 Volunteers
Volunteers will participate in a one day training course conducted by the supervisors. The course will take place in each **cluster**. **(for budget/incentive rates see chart on page 10)**

5.5.3 Social Mobilizers
Social mobilizers will particiapate in a one-day training organized and conducted by the district coordinator

5.6 Social mobilization

The PEMT and the district coordinator along with the supervisors will identify social mobilizers. One social mobilizer will be identified for each cluster in the district and will receive a one day orientation.

Message to be given prior to NID's:	
What is going to happen?	The Ministry of Health will conduct two campaigns to immunize all under-5 year old children with two doses of OPV, one month apart and administer vitamin A during the 2nd round of the campaign.
What are the dates?	**First round: 01-03 May 2000** **Second round: 03-05 June 2000**.
Which children will be immunized?	All boys and girls less than 5 years of age irrespective of their prior immunization status.
Why is it important to bring the child?	OPV protects the child against polio. To fully protect the child during the NIDs it is important that he or she receives a dose during each round of NIDs. By giving OPV to the children during the campaign not only the child will be protected but also it will help Afghanistan together with the rest of the world to eradicate polio by year 2000.

5.7 Flow of vaccination at OPV post (Suggested flow at the OPV site):

FIRST ROUND OF NID'S:

Volunteer A	➡ Warmly greet the caretaker and congratulate him or her for bringing the child; ➡ Determine the age of the child. ➡ Mark the on the tally sheet under the sex of the child with ✓ in OPV. Do not mark anything under vitamin A. ➡ Request the caretaker to take the child to volunteer B.
Volunteer B	⬇ ➡ Explain to the caretaker that the child will receive two drops of OPV and that the vaccine protects against polio. ➡ Give the child 2 drops of OPV. ➡ Inform the caretaker of the day that the team will be back and explain that he or she must bring all under-5 children next time for another dose of OPV.

SECOND ROUND OF NID'S:

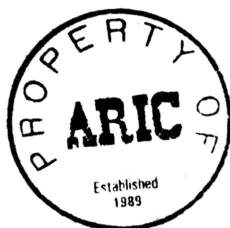
Volunteer A	➡ Greet the caretaker and congratulate him or her for bringing the child; ➡ Determine the age of the child. Then decide if the child is older than 12 months. ➡ Mark the ❍ on the tally sheet under the sex of the child with ✓ in OPV and with ✓ in vitamin A if the child will receive vitamin A. ➡ Request the caretaker to take the child to volunteer B and tell volunteer B whether the child shall receive vitamin A as well along sidè the OPV dosage.
Volunteer B	⬇ ➡ Explain what vaccine is given and that the vaccine protects against polio. ➡ Give the child 2 drops of OPV ➡ Then give vitamin A to the children older than 12 months as indicated by volunteer A. Explain to the caretaker what vitamin the child is receiving and that it increases the child's immunity/resistence to severe disease. ➡ Inform the caretaker that he or she should bring the child to the health centre for additional routine immunization.

5.8 Budget

Persons participating full time in the NID's will receive an incentive as follows:

Type of responsibility	No of days	Rate US $	Total US $
Supervisors	5	3.0	15
Volunteer	3	2.50	7.50
Social mobilizers	3	2.00	6

For training, a flat rate of US$ 2 will be paid to all resident trainees and a flat rate of US$ 4 to all non-resident trainees. Persons that cannot reach the training site within the same day of the training will receive a one day incentive. Social mobilizors will receive an incentive for a one day orientation.



The low coverage results in high maternal and child mortality and morbidity related to vaccine preventable diseases. Polio is still a cause of disability among children. In 1999 there were 150 AFP cases of confirmed polio (source: AFP surveillance).
The main causes of low coverage are:

- Inadequate communication with parents and authorities, especially in hard to reach communities.
- Lack of mechanisms for communities involvement in NIDs planning and AFP surveillance
- Insufficient motivation and skills of service providers;
- Limited number of female vaccinators;
- Inadequate management and resource allocation;
- Non optimal coordination among MoPH/UN/NGOs;
- Lack of a strategic communication plan integration within EPI/Polio Eradication plan

All of the above within a context of political instability and institutional disruption.

Day – 2

1. Problem behaviour and behaviour/participants/audience analysis

Problem behaviour	Manifestation	Behaviours to promote	Barriers to ideal behaviour	Factors encouraging ideal behaviour	Programme Communication		Social Mobilisation	Advocacy
					Primary Target	Secondary Target		
1. Local authorities and medical professionals do not perceive the NIDs/polio eradication as Afghan priority.	low coverage of EPI/polio	local authorities and medical professionals committed to/involved in Polio Eradication	- other priorities - limited understanding - lack of knowledge	- MoPH/UN/NGOs collaborate at all levels - International and local media - Cease-fire for NIDs, May 2000 - Cross-frontline activities possible during NIDs 2000 - Training and orientation takes place - Existing surveillance systems			Imam Community leader NGOs Teachers	District Administrator Medical Officers Health Director Medical professionals (Doctors, nurses and pharmacists)

Problem behaviour	Manifestation	Behaviours to promote	Barriers to ideal behaviour	Factors encouraging ideal behaviour	Programme Communication		Social mobilisation	Advocacy
					Primary Target	Secondary Target		
2. EPI/polio service providers do not communicate effectively with parents and care-takers	Low immunisation coverage	EPI/service providers communicate effectively	- local staff from other localities (only NID) - low literacy level of the parents - insufficient time during NID - cultural barriers (female participation) - low motivation of staff - illiterate vaccination/ health staff, selection criteria for staff are not followed.	- religious networks - system of incentives - commitment of authorities - availability of donor funds - communication materials on communication skills (NGOs)	Volunteers Social mobilisers Vaccinators EPI focal points TBAs	Supervisors District Coordinators Technical field staff of UN and NGOs		Donors Vice and virtue Dept Local administration